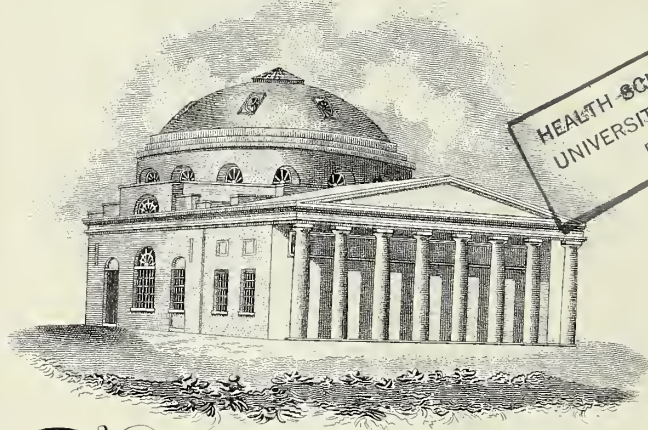


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THE JOURNAL

OF THE

Indiana State Medical Association

VOLUME 37
NUMBER 1

INDIANAPOLIS, INDIANA, JANUARY, 1944

Per Year, \$3.50
Single Copy, 50 cents

"MEDSOC" AUTHORS



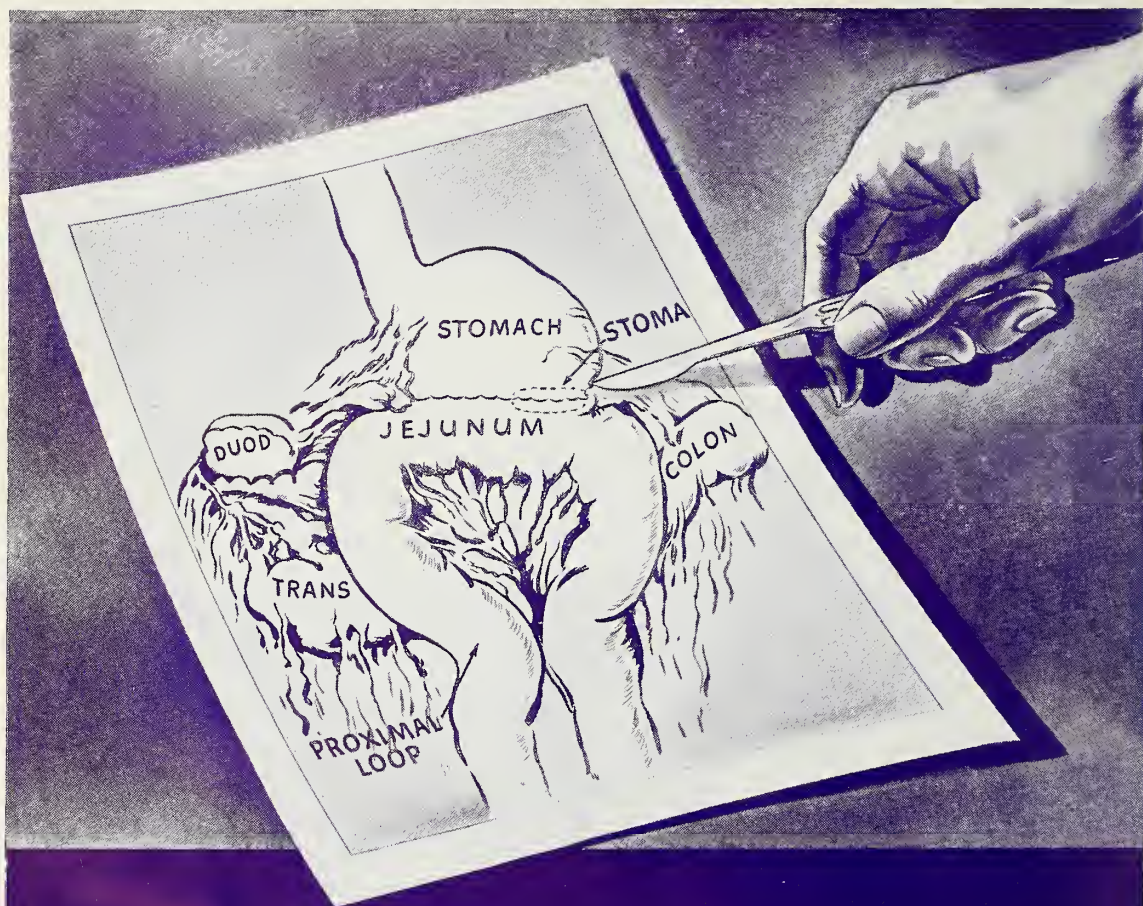
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INDIANA STATE MEDICAL ASSOCIATION

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ISSUED MONTHLY *under Direction of the Council*

OFFICE OF PUBLICATION: 1021 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

JANUARY, 1944

NUMBER 1

CHRONIC UNDULANT FEVER OF SWINE ORIGIN AS AN IMPORTANT PUBLIC HEALTH PROBLEM

THURMAN B. RICE, M.D.*

INDIANAPOLIS

Our present understanding of undulant fever has been a continued story covering almost a half century. The first discovery of the organism causing Malta fever was made in 1887 by David Bruce. At that time it was supposed that Malta fever existed only in the Mediterranean countries. We here in America felt quite safe from the disease. The germ, as discovered by Bruce, was one that presented many difficulties in study. As a matter of fact, it has held some five or six different scientific names since the time of Bruce just because it has been so difficult to study.

The next real step in the understanding of this disease was made when Bang in 1898 discovered the cause of contagious abortion in cattle, the disease now officially known as Bang's disease or brucellosis. The causative organism has been called Bang's bacillus, or *Bacillus abortus* (*Brucella abortus*). That the disease was one that could be transmitted to human beings was not known at that time.

The next really important discovery was made in 1918 when Alice Evans, of the United States Public Health Service, found that she could not distinguish the organism isolated from goats (called at that time *Bacillus melitensis*) from the organism of Bang (known as *Bacillus abortus*). Such being the case, there seemed no reason why we might not have here in the United States the disease known as undulant fever, derived from the infection in cattle instead of goats. We had supposed that there was almost no undulant fever in this country because we used so little of the milk of goats. A few goat-borne cases had been reported in Texas, but it was generally doubted that the disease was prevalent in the United States. As soon as it was realized that the organism was

the same as the one that caused the very common disease known as contagious abortion of cattle, search began to be made for the disease in human beings. Very soon it was observed that it is actually a common human infection and that a great deal of morbidity and a small amount of mortality can be traced to this source. Actually, when about ten or twelve years ago Doctor Francis, of the United States Public Health Service, in a session of the Indiana State Medical Association warned us that the disease was more important in Indiana than typhoid fever, it was very hard to believe that such could be true. We definitely took his statement with a grain of salt.

About that time the work of Huddleston, of Michigan State College, Simpson at Dayton, and Giordano and Sensenich at South Bend began to call attention to the fact that we have a really serious problem. An outbreak of the disease among the students of Earlham College, who had been drinking unpasteurized milk from a model dairy, called the disease to our attention in a most forceful way. It was, however, for the most part an infection with which doctors were not familiar. As time has gone on we have recognized more and more of the cases from the clinical standpoint and have developed certain clinical and laboratory tests which have been quite useful. For example, it is easily possible to draw the blood of the patient and to set up an agglutination test with the organisms. In this way it can be determined whether or not the individual is in possession of active agglutinating power against the organism. If his agglutination titer is high, it is generally supposed that he had the infection at the time the blood was drawn or very recently. If his clinical symptoms are such that they seem to indicate the same, the diagnosis is usually made. Likewise, there are tests whereby cattle can be tested to see whether or not they have the infection. A skin test has been developed

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for human beings which is of use in determining chronic infection or the ability of the skin tissues to react to the organism as a result of some previous experience with the germ.

Strong efforts were made to eradicate the disease in dairy herds, there being two incentives in such an effort. In the first place, this disease is the cause of serious economic loss to the owner of the herd. Then there is always the possibility that the milk may transmit the disease to those who drink it. When the milk is pasteurized this danger is eliminated provided that the pasteurization is done properly. Such being the case, we have developed a considerable degree of complacency with regard to the disease in cattle and have tried not too hard to develop abortion-free herds or to insist that all milk used for human consumption should be pasteurized. This comfortable program, however, has by no means accomplished the end which was desired, and there has been some wonderment why this should be true. It seems now that we are acquiring facts which will explain this situation and which may also explain a number of things which have not been understood in the past.

This new step forward is based upon the realization that this germ has more than one form. There is the caprine or goat form, which goes under the name of *Brucella melitensis*. Then there is the cattle or bovine form, which is given the name of *Brucella abortus*. For several years we have known that there is also a swine or porcine form of the germ, which is given the name of *Brucella suis*. This last strain or species of the germ has not in the past received the attention that it deserves. It has been looked upon as a curiosity, there being, it seemed, very little reason to fear it. In the first place, it does not occasion as much economic loss among hogs as the corresponding form does among cattle. The second cause for complacency was due to the fact that inasmuch as we do not use the milk of swine there seemed to be no reason to be alarmed. The idea that the disease might be transmitted in other ways has not been appreciated until comparatively recently. As a matter of fact, it is now known that the porcine form of the disease in man is much more severe than the bovine, and that an individual suffering from an infection of *Brucella suis* really has something to complain of. One might ask, "How would such an infection be transmitted?" We are now in a position to answer that question in an authoritative manner. The infection can be contracted by handling the diseased hog in the living state or by handling the flesh of the diseased hog when it has just freshly been killed and the body fluids are still quite fresh. It is likely that the disease can occasionally be transmitted from the meat after the animal has been hung, but this probably does not happen nearly as often as might be supposed. Inasmuch as this germ is not easily killed by drying, there is reason to believe that the dust or the mud in the hog lot may also be a source of infection.

One might suppose that the herds of hogs that are infected with this disease would be those typical "razor-back" animals that are seen in the hog lots of the farmers who are not very careful about such matters, and that it would be a comparatively easy matter to get rid of these animals since they are not valuable. Actually, the situation is quite different. The most frequently infected herds, beyond any doubt, are the highly pedigreed animals which are taken to county and state fairs and which are sold and shipped over considerable distances about the state or over the entire United States. It is obvious that this is going to make the matter of eradication quite difficult because one does not like the idea of killing a valuable pedigreed animal which is known to be infected but which does not itself seem to be ill. It must be borne in mind that animals can be dangerously infective to other animals and to man although they themselves show very minor symptoms if any at all.

The exact manner of infection in swine is not always known. It is likely that animals can be infected simply by contact with each other as they lie together in a pen, particularly at the time of parturition. Then, too, there is some evidence that it is a venereal type of infection among the hogs, the male giving it to the female and vice versa. It is now well known that certain small animals and cattle can be inoculated simply by dropping the culture of *Brucella suis* upon the apparently intact skin. In other words, this is an infection that can go through the normal skin, thereby greatly complicating the matter of contagion. There is considerable evidence to indicate that the human likewise does contract brucellosis through the unbroken skin.

We are coming to realize also that the really serious phase of the disease is the chronic rather than the acute form, partially because the chronic form of the disease is so frequently not diagnosed. An individual who has the acute infection is ill enough to be very uncomfortable. He has no assurance whatever that when this attack is over he will not be left as a chronic case who may be frequently uncomfortable over a long period of time and who may be essentially an invalid for years to come.

The treatment of this disease has been rather well discussed in many places and need not be repeated here other than to say that rest in bed over a long period of time is highly essential. Certain of the sulfa drugs (particularly succinyl-sulfathiazole) seem to be useful, and there is good reason to believe that the use of *Brucella* vaccine may be of value in some cases. There is a serum on the market which is of use in very acute cases in which the individual seems likely to die of the infection. The disease is of such a nature that nothing can be promised as to a complete or satisfactory cure. The most important thing in arriving at such a desired end is that the patient be kept in bed much longer than seems absolutely

necessary. Even then, however, a great many cases will relapse and will have recurrences, especially in hot weather or at such a time as the apparently cured individual indulges in heavy mental or physical work or any other debilitating experience. It is interesting in this direction to remember that the patient's associates will frequently say that there is nothing wrong with him except "imagination." These people are often accused of being lazy or of being neurotic. Alice Evans, who suffered for many years from the disease, has said that the physician has no right to make a diagnosis of "neurosis" until undulant fever has been eliminated.

The porcine form of the disease in a human being is essentially an occupational disease of certain groups who are grossly exposed. As a matter of fact, many veterinary surgeons have been ill of this disease at one time or another. They are, of course, constantly exposed as they handle sick hogs. The incidence among veterinarians who do practice involving the treatment of swine is very high indeed. Almost any group of veterinarians who meet to discuss the subject will constitute a pretty fair clinic to demonstrate the nature of the disease. This has been observed by a number of persons and is one that has caused the members of the veterinary profession a great deal of anxiety and concern.

The next group for which it might be considered an occupational disease is the butchers, and especially the slaughterhouse men who handle the diseased hogs when freshly killed. Rather recently there has been an epidemic of this kind in the State of Indiana among the employees of a slaughterhouse in which about 10 per cent of the men who handled the freshly-killed animals have come down with the infection in the course of a year or so. A number of these people have been ill for weeks and have no assurance whatever that they may not be rather seriously handicapped for years to come. Because the earning capacity of an individual is dependent upon his being able to continue his work with some degree of comfort and efficiency, an individual with acute porcine undulant fever or a relapse of the same is definitely going to be on the retired list for the time being, and is going to be extremely uncomfortable.

The third group which is likely to show this infection consists of those persons who are farmers or hog raisers (and who are less intimately in contact with the disease than are the two preceding groups). The disease is rather common among farmers although it has many times been called something else. In times past, especially, it has been called malaria, typhoid fever, "walking typhoid" fever, bilious fever, arthritis, rheumatism, tuberculosis, general "run-down" condition, and a great many other similar names. The chronic form is very likely to be considered as being just general ill health or a neurosis. It is apparently often the cause of arthritis, which disease is so

common among farmers and which is usually explained on the ground that the individual has always "worked very hard" and that his joints are therefore worn out. He believes that he cannot expect to be very comfortable, but that he is stiff from too much hard work and is old before his time. Anyone who has been among farmers very much will recall that this group constitutes a considerable proportion of the population over forty-five or fifty years of age. There is no doubt whatever that there are other causes of arthritis among these people, but there is also good reason to believe that a considerable portion of it may come from this source.

We are strongly inclined to think that this chronic form of the disease, which is only recently being appreciated, in the next ten years will be one of the really great public health problems before the people of Indiana, and other agricultural or hog-raising states. One prominent authority has estimated that probably 70 per cent of the really important cases of undulant fever are of swine origin. It is interesting, however, that it appears to be impossible to pass the disease from one person to another. It must always come from the animal. It is also interesting to know that children rarely have the disease, just as young animals rarely have it. As a matter of fact, in cattle, at least, we think that it is extremely unlikely that a calf will have the disease until the reproductive organs, the uterus and udder in the female, have reached full or nearly full functional development. In the human being there are many cases in which women have had the disease while pregnant and did not abort. Furthermore, they have nursed the child and have not given the disease to the child. It appears, therefore, that there is no likelihood that it will become epidemic among human beings as a disease passed from one human being to another.

Some thought has been given to the various means by which this disease might be eradicated from the swine herds. It is definitely a much more difficult problem than in the case of cattle. There are several reasons for this. In the first place, the method of diagnosis is less accurate and therefore will require a great deal more testing to determine which animals have the disease. In the second place, the animal raiser is not going to be so enthusiastic about an effort of eradication for the reason that the disease does not usually harm the herd as much as it would a corresponding herd of cattle. In the third place, apparently it will be harder to arouse general interest in the matter because the general population is not much concerned. This situation would likely change if all of the obscure ailments of people that are due to *Brucella* infections were properly diagnosed. In the fourth place, the habits of the hog are such as to make it much harder to prevent the transmission from one to another of the animals.

In general, two plans have been proposed. One of them is that the animals be tested to determine

which herds have the infection. When a herd is found with the disease it would then be possible for the entire herd to be slaughtered. It would seem in such case as if the meat would be unfit for human consumption. Such is not the case. The meat seems to be perfectly wholesome if properly cooked, and it does not seem as if there is much, if any, danger in handling the various cuts as they come from the butcher's block. The danger would be to the men who are actually killing the animals. They should be warned that they are killing infected animals, and precaution should be taken against infection. Perhaps these animals could be killed at the end of the day and the men's hands during that short period be protected with rubber gloves. Then with a thorough shower bath just afterwards it might be that the danger of infection would be considerably reduced.

This would seem to be an ideal time (1944) for the consummation of such a plan, if it could be organized in the short space of time offered. With other things occupying our attention, however, it is rather unlikely that a plan of this scope could be developed in the short time that we have before the hog population will probably be sharply reduced for other reasons. It will require a great deal of education of the farmers and of the public in general to support this kind of a program. At some later time it possibly may be not too hard to put into effect some plan for eradication due to the short life of the animal and the comparative small unit which a given animal constitutes. It would be possible to test the blood of the animals and determine which ones had the disease by simply drawing blood from each one of them. After these bloods are drawn the tests can be made for about ten cents a head, so the cost is not prohibitive.

Another immunization plan would be for those who handle the animals to be immunized against the infection. We are familiar with the use of the vaccine as a means of treatment in both acute and chronic cases, but there has been very little actual experience with the use of the vaccine as a means of immunizing those who handle the animals. We see one difficulty however. The vaccine that is now on the market is a *Brucella abortus* or *Brucella melitensis* vaccine and is presumably most useful against that infection which is contracted from cows or from drinking unpasteurized milk. It would seem that the vaccine to be used in this instance should be from *Brucella suis* strains and therefore should be more highly specific for the disease which we are attempting to prevent. This is easy to say, and we only wish that the practical problem were as easy as it is to set up this idealistic scheme on paper. The difficulty lies in the fact that all of the *Brucella* vaccines are quite toxic and that an individual having taken the vaccine is liable to get a pretty severe reaction. This would be bad enough even in the case of *Brucella abortus* vaccines, but is much more serious in the case of *Brucella suis* which is definitely

more toxic than *Brucella abortus*. It would be a considerable and dangerous undertaking, as we understand the matter, to immunize an individual so that he would be sufficiently immune to be really safe. If we gave him a few large doses we could count on his becoming quite ill, probably by each of the doses. This vaccine is very prone to cause necrosis and sterile abscesses and then these abscesses heal slowly. Neuritis is a common complication. If small enough doses were given so that we would avoid the possibility of a sterile abscess or unpleasant reaction, it would mean that a great many injections would have to be made. We are all familiar with the fact that farm people do not like to come to the doctor's office a great many times to take shots to protect them against a disease which they feel they would probably not get. It is possible that a large number of injections would be necessary to immunize an individual although we cannot speak authoritatively on this subject because so far as we know little has been done in this direction.

Even though a large number of small doses were given, it is likely that occasionally a person would be made extremely uncomfortable. Very little has been done in the way of using *Brucella suis* vaccine. Here is a field for investigation that really should be taken up at an early date. It is possible that we may find a way to live with this infection, but there seems to be no easy way out of the present difficulty.

We then are on the horns of a dilemma with regard to this disease as it is manifested in those who handle hogs. Further complication lies in the fact that other animals may have this form of the disease. For example, cattle may contract the porcine form from hogs, and then the human being may get the disease from the cow. Fortunately, the reverse form of infection, that is from the cow to the hog, seems to be quite rare. The rat must be considered as a reservoir of infection. To eradicate the disease from the hogs we would have to have some assurance that we have eradicated it from rats.

It is interesting to learn that the disease sometimes attacks horses, causing a lesion which is known as fistula-of-the-withers and poll-evil. The two localizations of the disease in horses are at the respective ends of ligamentum nuchae, which is the elastic ligament that holds up the head, poll-evil being at the base of the skull and fistula-of-the-withers being above the shoulder region. The individual who handles horses with this infection may become contaminated.

At the present time the disease seems to be a particularly hard nut to crack, and we hardly know where to make a start. It seems quite clear that this is a disease which calls for a great deal of extremely high-powered research. It would be almost futile for a single laboratory worker to attempt to solve the tremendous problems involved in this infection. Large research institutes would have to be set up where large sums of money

could be spent in buying animals and making the various tests. It would be well, too, if this research experiment was associated with some medical center where human cases could be studied. As a matter of fact, there are some six or eight large research projects going on at the present time; for example, there is one at Purdue University, one at Iowa State, Michigan State, Minnesota, California, and the United States Bureau of Animal Industry has one at Beltsville, Maryland.

We are very glad to know that the Department of Agriculture of the United States Government is much interested and that they are supporting research along these lines. There is no doubt whatever that this is a public health problem of major importance, and we predict that a few years hence it will be given very great prominence.

In summary, we might point out that four things are definitely known concerning undulant fever:

(1) There is no longer any reasonable doubt as to the existence of a disease in man caused by *Brucella* organisms.

(2) There is no evidence to indicate that one human being ever contracts undulant fever from another human.

(3) In the light of our present knowledge, the satisfactory control of undulant fever is dependent upon the control and elimination of brucellosis in our farm animals.

(4) The porcine strain (*Brucella suis*) is responsible for a large percentage of the cases and causes a particularly severe infection.

PENTOTHAL SODIUM—RANGE OF USEFULNESS, COMPLICATIONS AND THEIR MANAGEMENT*

GEORGE J. THOMAS, M.D.†

PITTSBURGH, PENNSYLVANIA

The intravenous method of administering an anesthetic agent has a strong appeal to the experienced anesthetist, the surgeon and the patient. This method has, further, the advantage of causing a patient to traverse from the first to the middle of the surgical stage of anesthesia within a period of one to three minutes. Such rapidity of action is an improvement over the ten- to fifteen-minute period required for inhalation anesthetics to take effect.

Intravenous anesthesia started in 1930 in a small way. In 1935, however, the real momentum began for this type of narcosis. We felt it advisable, before becoming very enthusiastic about this method of anesthesia, to make an extensive clinical and laboratory survey.¹ Among several agents studied we found pentothal sodium to have the following advantages over other intravenous agents:

1. It is equally, if not more, powerful and rapid in action.
2. Twitching and jactitation are rare.
3. Postanesthetic nausea and vomiting are less frequent.
4. Relaxation appears to be more satisfactory.
5. Recovery is more rapid.

* This paper was submitted before the Section on Anesthesia of the Indiana State Medical Association, at Indianapolis, Wednesday, September 29, 1943.

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¹ Thomas, George J.: Clinical and Laboratory Observations on Intravenous Anesthesia, *Current Researches in Anesthesia and Analgesia*, 17:163-168 (May-June) 1938.

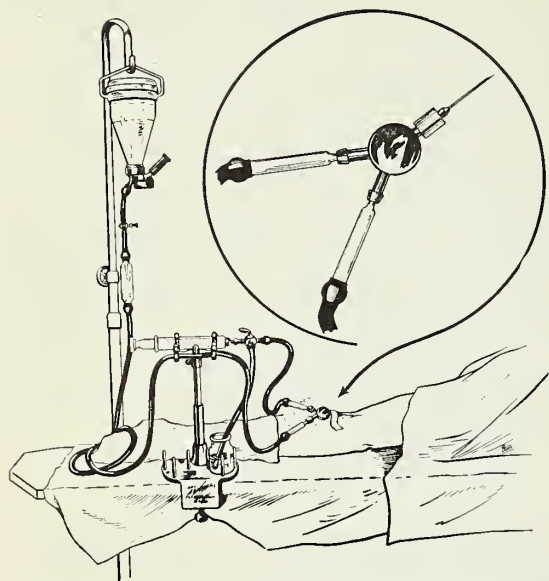
RANGE OF USEFULNESS

Pentothal sodium has a wide range of usefulness in surgery and medicine, such as:

1. A general anesthesia. It is an ideal agent for surgery of the head, breast, extremities, hernias, perineal region, et cetera.
2. A rapid and a pleasant induction preliminary to gas anesthesia.
3. A supplement to local, spinal or caudal analgesia. It is very useful with continuous caudal or spinal analgesia. A unique method is to give 10 per cent glucose by the continuous drop method through one limb of a manifold and pentothal sodium through the opposite limb. The male adapter of the manifold is attached to an intravenous needle. Such a setup facilitates the administration of glucose continuously and pentothal intermittently through a single needle (see Figure I).
4. To combat any toxic effect of a local anesthetic. Should a reaction occur under local anesthesia, inject intravenously two to four cc. of a 4 per cent solution of pentothal. This procedure will counteract the toxic effect of cocaine or its derivatives.
5. To relieve convulsive states that occur with drug poisoning, tetanus, eclampsia, ether anesthesia, et cetera. The treatment is the same as described in No. 4.

Pentothal sodium may be administered rectally or intravenously. Rectal administration is ideal for inducing unconsciousness and averting psychic shock while transferring the patient from his bed to the operating room. However, the intravenous method is the most practical.

FIGURE I

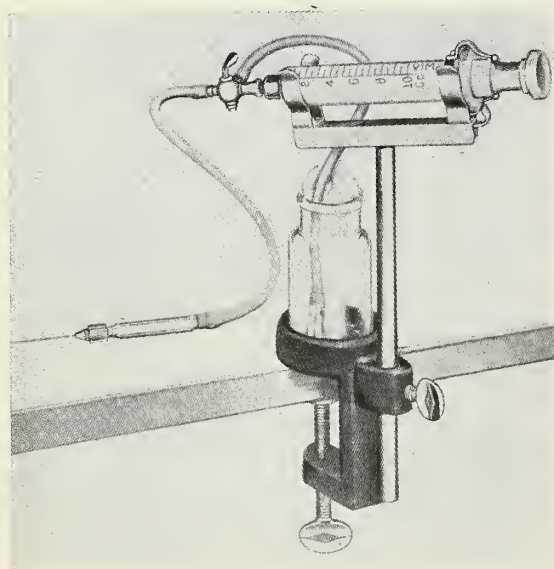


"Double setup" apparatus for administering the supplemental solution and pentothal.

TECHNIC OF ADMINISTRATION

Preoperative Medication—Sufficient and proper preoperative medication is absolutely essential for a smooth pentothal anesthesia. Opiates are used, with special emphasis placed on the necessity for atropine. These preoperative agents control the parasympathetic hyperactivity and inhibit salivary and mucous secretions, thereby greatly reducing the incidence of complications such as coughing, sneezing, and laryngospasm. The preoperative medica-

FIGURE II



Thomas intravenous apparatus No. 11, used in the intermittent technic of administering pentothal sodium.

tion should be administered hypodermically thirty to forty-five minutes before the anesthetic.

Administration of Pentothal—The dose can not be accurately judged by the patient's weight, age, sex, or metabolic state. The dose must be adjusted to each individual patient. In order to obtain the proper depth of narcosis for the particular type of operation, one must resort to the intermittent technic in the administration of this agent. In our institution this technic is made possible with the use of an inexpensive apparatus. This consists of a small stand that can be clamped on an arm board, as illustrated in Figure II.

The base supports a reservoir for the pentothal solution, and an adjustable bracket attached to the stand holds a syringe. A two-way stopcock is attached to the syringe, to each outlet of which is connected ordinary Dakin tubing eight inches in length. One tube leads to the reservoir and the other to the arm to which is attached a glass observation tube and a needle. Such equipment makes it possible to refill the syringe when necessary and to continue the intermittent technic indefinitely.

The operating field is prepared and draped. Venipuncture is performed after the skin has been surgically prepared. Three cc. of a 4 per cent solution of pentothal sodium is injected during a period of ten to fifteen seconds. A pause of seven seconds should follow the initial injection. Because relaxation comes on more slowly than unconsciousness, it is very important that a pause follow the injection of each 2 or 3 cc. of the agent. An additional 2 or 3 cc. is injected at the same rate as in the beginning, then there is another pause. This procedure is continued until the desired relaxation is obtained. The air passage must be patent. Oxygen must be administered with a gas machine or with a nasal adapter or a 22 French gauge whistle-tip rubber catheter inserted at a distance of five inches through the nose and into the pharynx (see Figures III and IV).

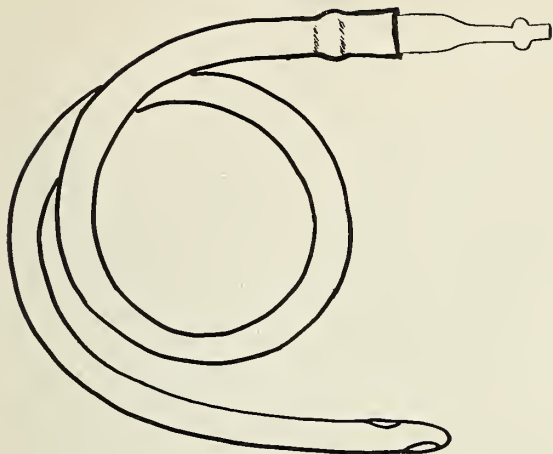
It must be remembered that since the agent is given intermittently the effect following the administration of each successive dose is increased. The pause between injections is highly important because the cumulative effect of the drug may come on very suddenly. Evidence of recovery is an indication that an additional 1 to 2 cc. of the solution is necessary. Caution regarding speed of injection can not be overemphasized. As in all types of anesthesia, the body has no active mechanism of defense against overdosage. The operating room is no place to demonstrate the miraculous speed of induction with this potent agent. A sacrifice of a little time will increase the safety factor in anesthesia.

Intravenous anesthesia should never be started unless oxygen alone or a gas machine is available.

COMPLICATIONS AND THEIR MANAGEMENT

With pentothal anesthesia complications are rare. However, some occur and should be handled without

FIGURE III



22 Fr. Gauge Whistle-Tip Catheter

Twenty-two French gauge whistle-tip catheter.

serious results. The most common is respiratory depression. The amplitude of the respiration, rather than the rate, is affected. We found that oxygen administered through a mask or a catheter is frequently sufficient to stimulate the respiration, although we occasionally find it necessary to administer nitrous oxide and oxygen, in the meantime reducing the amount of pentothal. This technic has become quite popular with our staff.

Other complications are coughing, laryngospasm, and hiccups, which may occur either in deep or light anesthesia. These may cause alarming cyanosis and perhaps cardiac embarrassment, if persistent. Such complications are undoubtedly due to parasympathetic hyperactivity. Prophylactically, we find that the administration of atropine in proper amounts will readily control these complications. However, should they occur under anesthesia, we aspirate the mucus or other material in the pharynx, deepen the anesthesia and immediately administer nitrous oxide-oxygen under pressure.

Trismus (a tetanic spasm of the jaw muscles) is another complication. This is undoubtedly a result of parasympathetic hyperactivity that can be controlled with atropine preoperatively. Should this occur during anesthesia, a nasopharyngeal tube should be inserted immediately and oxygen administered under pressure. Delay in this procedure may be serious.

Sneezing usually occurs in eye surgery. When the eye is prepared, the cleansing solution passes through the nasolacrimal duct, irritating the delicate nerve ending of the nasal mucosa and resulting in sneezing. This must be treated preoperatively. We instill two drops of 4 per cent cocaine in each eye thirty minutes before the operation, again ten minutes before operation, and again immediately before starting the anesthetic.

Urticarial rash has appeared on three occasions in our series of cases. It occurred during the induction of the anesthetic and is an interpretation of the idiosyncrasy of the patient to that drug. If nembutal is given the night before the operation, the patient will reveal this susceptibility and this type of anesthetic can be avoided. However, should the condition occur during anesthesia, discontinue the pentothal and immediately administer four to six minims of neosynephrin intramuscularly. The anesthetic should then be continued with inhalation agents, preferably nitrous oxide or cyclopropane.

POSTANESTHETIC COMPLICATIONS AND THEIR MANAGEMENT

The most common postanesthetic complication is respiratory depression. For this reason all patients anesthetized with pentothal should have oxygen administered to them continuously after the operation until they have completely reacted. Furthermore, the entire nursing staff of all hospitals should be thoroughly trained in the proper management of patients receiving barbiturates. The nursing staff should be made to realize that the post-operative and postanesthetic care of patients is very important for uneventful recovery.

Postanesthetic opiates should be withheld, especially in the case of older patients, until the patient has completely reacted from the anesthetic.

If a patient has not reacted within two to three hours, it means that a toxic dose of pentothal has been administered, and that the condition should be treated accordingly, that is:

1. Keep the patient warm.
2. Establish a patent airway.
3. Administer oxygen continuously. This should be given through a nasal catheter.

FIGURE IV



The 22 French gauge whistle-tip catheter inserted into the pharynx.

4. Aspirate the mucus from the throat frequently and place the patient in a 10 degree Trendelenburg position.
5. Give 1 cc. of picrotoxin intravenously every twenty minutes until a slight twitching of the facial muscles is noted; then give 1 to 3 cc. of picrotoxin intramuscularly every half hour for four doses; and then 1 to 3 cc. every hour until the patient reacts.
6. Sucrose administered intravenously for diuresis and dehydration of the brain and lungs is helpful.
7. Repeated administration of plasma is very helpful. However, repeated small transfusions are to be considered if the patient has lost a moderate amount of blood during the surgical procedure.

CONTRAINDICATIONS

Pentothal sodium should not be employed or recommended when there is a marked physiologic or mechanical interference with the respiratory function. It is contraindicated in inflammatory conditions of the neck complicated by edema of the glottis, and in tumors of the neck encroaching on the glottis and interfering with respiration. Children under seven or eight years of age, unless very robust, are poor subjects. Apart from their natural fear and small veins, the inertia of the air in their narrow air passages hinders gaseous exchanges and creates an undesirable situation in view of their relatively high oxygen requirements. It is inadvisable to use this agent on patients suffering with respiratory embarrassment due to cardiac decompensation. I feel that it is contraindicated in the presence of bronchiectasis, severe anemia and shock. I also believe that pentothal is contraindicated in abdominal surgery when deep relaxation is important. Furthermore, cases of intestinal obstruction react poorly to pentothal sodium alone. Pentothal should be supplemented with block or spinal analgesia in this type of surgery.

CAUTION

There are borderline cases which may or may not contraindicate the use of pentothal sodium. These cases may be listed under the heading of "Caution."

1. Gross abnormalities of metabolic activity, such as thyrotoxicosis or myxedema. These may involve excessively rapid or excessively slow elimination of the drug.
2. In nasal and oral surgery one must be cautious in avoiding mucus and blood in the pharynx and larynx, since laryngeal irritability is heightened and spasm may result.
3. Care must be exercised in cases of coronary disease and hypotension. Nikethamide should be added to the pentothal solution when such conditions exist.
4. When using pentothal sodium for broncho-

scopies and esophagoscopies, cocaineization of the pharynx, larynx, and esophagus is absolutely essential in order to avoid laryngospasms.

CONCLUSION

I have attempted to give a brief review of pentothal sodium with special attention to range of usefulness, technic of administration, complications and their management, contraindications and certain cautions as to use. I wish to emphasize that pentothal is not a drug with which liberties may be taken. Special care should be exercised in maintaining an efficient airway at all times. A gas machine should always be on hand and ready for use should respiratory depression or other complications present themselves. Finally, the drug should be administered by a thoroughly-trained anesthetist who is competent to deal with any situation that may occur during the administration of this popular but potent drug.

DISCUSSION

FLOYD T. ROMBERGER, M.D. (Lafayette): We are indeed highly honored in having Dr. Thomas with us. I have known him for a great many years and the more I see him the more I appreciate what he is doing for anesthesia, not only in the intravenous type but in other types as well.

This little Section is nine years old. Next year we will celebrate our tenth anniversary. I am very proud of the fact that every year without exception we have brought into Indiana from some outside state someone of value. I know that with the presence of Dr. Thomas you will agree that this is done.

In my own practice I began with intravenous anesthesia about 1928, using amytal. Up to 28 or 30 grains were used. The results were not so good; they were not what we thought we should get from the literature and from the descriptions the detail men gave, so it fell into disuse. About six or eight years ago, with the advent of pentothal sodium and allied drugs, we began in a somewhat larger way. In our city we do not as yet use pentothal sodium or evipal to the full extent. I should like to see it used, first because we do not use it extensively enough. We use it mostly in eye cases, cystoceles and operations upon the limbs. We have not used it in intra-abdominal work. The reason is that we have been reasonably successful with our administration of spinal anesthesia.

In the future I am going to be a little more alert in the preoperative preparation of these patients. My experience bears out the statements of Dr. Thomas. My routine has been to give by mouth $1\frac{1}{2}$ to 3 grains of seconal an hour before, and morphine, gr. $\frac{1}{6}$, and atropine, gr. $\frac{1}{150}$, three-quarters of an hour before the operation. I use upward of two grams or a little more or less of pentothal sodium. We do not use oxygen routinely, but we have the oxygen apparatus on hand in case

it is needed. As pointed out by Dr. Thomas, in every single instance we use the four-wire airway. That is very necessary for the nasal administration of oxygen. Personally, I do not know what per cent of pentothal sodium I administer. At first I very carefully measured and calculated as well as I could, 5, 4, 2½ per cent, but as my experience gained I undertook to administer pentothal sodium just like I would ether, chloroform or any other inhalation type of anesthesia; that is, I use my patient as the index in considering the amount to be employed. I defy anyone of you, using local or ether, to tell me from minute to minute intervals the percentage of ether under the mask. However, I have given ether anesthesia on an open mask so long that we have become accustomed to using the patient as our index. I have tried in my own simple way to apply that same method to intravenous drugs, using the patient as an index. I dissolve one gram of the drug in 20 cc. of distilled water. I use the Thomas outfit with the single syringe. I use sufficient water to make a bottleful. If the patient is under very nicely, I simply use up a half bottle and put in sterile water and keep on giving 2 cc. or ½ cc. as necessary.

It was my very happy and delightful experience to spend a little time with Dr. Thomas in Pittsburgh two years ago last June. Frankly, between you and me, the reason I went there was to learn how to improve my technic. I could not hit the veins as I expected, and I went there to see what luck Dr. Thomas was having. He was not having much better luck than I was, but I got some ideas. I wish he would give us a very short, snappy lesson on how to do a venipuncture in some of these patients. I always feel that when the venipuncture is made I am quite safe. It is a very difficult problem in some patients with very small veins, especially women, to make a puncture.

Your paper was marvelous, Dr. Thomas, and I am delighted that you are here. It is a privilege to have you, and I hope that you are having a good time.

LILLIAN B. MUELLER, M.D. (Indianapolis): I have been a very enthusiastic user of sodium pentothal. Dr. Thomas said that it was contraindicated in surgery of the nose and throat. This is true unless an endotracheal tube is used. I would like to tell very briefly about a case I had just before I came down here.

The patient was a thirty-two-year-old woman with a malignant tumor of the nares, which the surgeon was going to remove by electrosurgery. Before starting I put down an endotracheal tube, then gave nitrous oxide, and then started the sodium pentothal. The first 20 cc. was a 2½ per cent solution; after that I diluted it half, using 1¼ per cent, and it worked beautifully. We have done several cases like that in our work with the oronasal surgeons who are operating on malignancies of the nose and throat. They are very much pleased with the anesthesia. We pack the

pharynx with gauze to keep out the blood and secretions.

Dr. Thomas, you read Dr. Beecher's article telling how very dangerous pentothal sodium is. Our genito-urinary men are afraid to have us use it. Have you found it as detrimental and as dangerous as Dr. Beecher's article would lead us to believe?

CHARLES N. COMBS, M.D. (Terre Haute): I studied pentothal sodium under Dr. Thomas five years ago. At that time I was particularly impressed with a remark he made, that not a single patient to whom he administered it had ever objected to its repeated use, and one patient had sixteen administrations. A single patient with about twelve or thirteen administrations is my limit in that particular. It certainly pleases me immensely when the patient wakes up from the anesthetic—with no regrets—which they did not always do with the use of some of the other forms.

CAPTAIN DONALD S. THATCHER, M.C., U.S.A. (Billings Hospital, Fort Benjamin Harrison): I would like to add one comment. In military hospitals it is not always possible for us to obtain the very nice apparatus that Dr. Thomas has illustrated, and so we have to improvise. I would like to mention a technic which we have been using at Billings Hospital for two years with good results. We use an ordinary piece of intravenous tubing, about thirty-six inches long, and attach one end to a glass adapter to which the intravenous needle is fitted, which is inserted into the patient's vein. Then we fill the metal cylinders with 2½ per cent pentothal, so we have the percentage we want to use, and connect the other end of the thirty-six-inch tubing to the cylinder. We are able to maintain a continuous and intermittent type of pentothal anesthesia by strapping the tubing to the operating table with adhesive, wrapping it in gauze saturated with alcohol to keep it reasonably sterile. We always use oxygen continually during pentothal anesthesia.

I would like to re-emphasize in my limited experience the dangers of laryngospasm in pentothal anesthesia. I believe that most of the preventable hazards of pentothal lie not in the syringe but in the patient's thorax and larynx. It is there that the disasters are initiated. We have given close to 40 per cent of our anesthetics for surgery on the extremities and the eye. We always avoid its use in surgery about the nose and throat. We have not noted the severe respiratory depression that was noted by Dr. Beecher in his article. We feel also that pentothal is just as safe as the experience of the anesthetist who gives it. However, the technic I have mentioned works out very satisfactorily in military hospitals where one medical officer anesthetist is responsible for four to eight operating rooms each morning.

May I presume to add just two points in technic to the points brought out by Dr. Romberger on the

question of venipuncture—two very satisfactory procedures that I have found of use if difficulty is anticipated in doing a puncture, either because of a thrombus or cicatricial scarring or deformities: I find it very useful if one can begin a half hour pre-operatively to wrap the patient's entire extremity in warm moist towels. After thirty minutes there will be considerable vasodilatation, and it will be easy to select a vein for puncture. If that fails, usually there will be available one or two veins on the back of the hand. By applying a tourniquet at the wrist just snugly enough to cut off the venous return at the hand, having the patient work the fingers as briskly as possible, then attaching to the syringe a regular hypodermic needle and having the syringe filled either with sterile salt solution or sterile distilled water, and picking up one of the veins with the tourniquet in place, one can very slowly inject the solution and dilate all the veins on the back of the hand distal to the point where the tourniquet is applied. Then take the venipuncture needle and puncture the vein, establishing the pentothal connection, and remove the tourniquet.

GEORGE J. THOMAS, M. D., (Pittsburgh, Pennsylvania) closing: I would like to thank the gentlemen for the fine discussion. The discussion of a paper is more important than the paper itself. That helps to make the paper, and the essayist gets all the credit for the paper that really belongs to the discussers.

I knew that Dr. Romberger had used amytal intravenously. I have been following Dr. Romberger and Dr. Combs for many years, long before they knew me, and they are responsible for my enthusiasm for anesthesia. Both have had more experience than I. In Pittsburgh we are on our eighteen thousandth series of cases and we have had to simplify our technic. We have a group of twenty-two people working in our department, and I have to set up a simple technic. That is why we had to get away from the two syringes. I would ask of the individual anesthetist, how much solution have you? "Three hundred cc." How long have you been using it? "Thirty minutes." That is too fast. Consequently, we have had to simplify the apparatus.

Dr. Romberger mentioned the airway. I would like to caution you in its use. I am like Dr. Lundy who said, "I am not foolish enough to not use an airway when it is needed in a patient." On the other hand, I am not foolish enough to put an oropharyngeal airway in every patient to whom I give pentothal. You frequently have laryngospasm because the barbiturates irritate the larynx. Laryngospasm, once it starts, sometimes can be very serious. We found one airway that helps us, that is a nasopharyngeal airway, a small tube we make ourselves, six inches in length, fastened at one end with a safety pin so it will not be lost. We have not had laryngospasm stimulated by the insertion of that small tube.

I quite agree with Dr. Romberger that the patient is your index for any type of anesthetic, not only pentothal but spinal or any other type. It is the amount of drug you give, the per cent is not an important factor.

With regard to venipuncture, I think that Captain Thatcher gave us a good discussion on how to find a vein. We like to go into the antecubital fossa because it is less painful to the patient. Occasionally we have a patient who does not have a very good vein in the fossa. We leave the tourniquet on and allow the hand to drop over the table for five or ten minutes and ask the patient to make a fist. We can bring out the vein in the snuff-box. With a good sharp needle and flexion of the hand, one can bring out the cephalic vein, which is the size of a small pencil, and the venipuncture can be completed in that area. We had difficulty, so we took turn about going to the genito-urinary clinic and serving a two months' assistantship, giving neosphenamine and taking blood for Wassermanns. In that way we learn to do a venipuncture. The veins in the dorsum of the hand can also be used. I quite agree with Captain Thatcher that the veins can be brought out by the method he described. The use of heat is quite beneficial, and I am very much indebted to him for bringing it up.

Dr. Mueller mentioned the use of pentothal in nasal surgery and oral surgery. I did not mean to say it is contraindicated in that surgery. When using it in oral or nasal surgery there are certain cautions that must be observed and that is caution against laryngospasm and against mucus and blood. The throat should be cocaineized, the same as for a laryngoscopy, and one should be sure that the airway is sufficient before allowing the laryngologist to go on with the operation. We use it in oral and dental surgery, but we always follow the same routine of cocaineizing the pharynx and larynx before we begin the surgery. That, I think, offsets the danger of laryngospasm.

Regarding Dr. Beecher's article, I have great respect for Dr. Beecher and for his associate, Dr. Moyer. There are certain precautions we must follow and we must respect their judgment in that pentothal does depress respiration. Pentothal will have some of the effects they bring out, and so we have an explanation for some of the deaths that occur on the table. The carotid reflexes are knocked out and the patient will die a respiratory death. We can offset the dangers by giving the anesthetic slowly, by giving oxygen and not too much pentothal.

In closing, I want to thank you for the discussion and I appreciate the opportunity of talking to you.

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TREATMENT OF ACUTE SUPPURATIVE OTITIS MEDIA BY LOCAL SULFONAMIDE THERAPY

A Report of 84 Cases

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During the period between December, 1942, and May, 1943, one of the major problems of the Eye, Ear, Nose, and Throat Department was the treatment of hundreds of cases of acute otitis media. Nearly 20 per cent of approximately fourteen hundred to eighteen hundred treatments given through the out-patient clinic monthly involved infections of the middle ear. Most of these cases were secondary to an acute upper respiratory infection, and many required hospitalization, either because of the severity of the case or because the primary infection justified hospital treatment. All of the patients in this report, however, were ambulatory and treated in the clinic. All came under the generally-accepted classification of acute suppurative otitis media.

From the outset, several routines of treatment were set up to care for the cases of acute suppurative otitis media. These methods followed approved, conservative, symptomatic types. From time to time several of the sulfonamide powders were tried by insufflation directly into the external ear canal. Observation soon showed that the insufflation of powdered sterile sodium sulfathiazole brought about almost an unbelievably rapid recovery with complete cessation of discharge and symptoms, as compared to other drugs of the sulfonamide group. A series of cases was studied with controls in order to determine accurately the efficacy of this form of treatment. Careful records were kept from the date the patient was first seen in the clinic during the course of treatment, and through the follow-up period. This report concerns eighty-four cases thus observed.

Cultures taken at the time of initial treatment proved the presence of Beta Hemolytic Streptococci in pure form in about 90 per cent of the cases. The remaining cases were divided between Staphylococcus aureus and albus, and Pneumococcus. In most of the cases of streptococcus infection the initial discharge was characteristic. A sero-hemorrhagic exudate, usually profuse in nature, was present for about twenty-four to thirty-six hours, later becoming mucopurulent, then as treatment progressed changed to a sterile mucous discharge.

The routine of treatment set up in the clinic consisted of thoroughly cleansing the external ear canal and tympanum of all discharge. This was done by

using sterile dry cotton swabs. An improvised insufflator for the sodium sulfathiazole powder was used to spread a thin layer of the drug over the tympanum and walls of the external ear canal. This routine was repeated daily on all patients as nearly as practicable through the day that the discharge ceased. All remaining powder from the previous treatment was removed before each subsequent insufflation. This helped to prevent caking of the powder which occurred only in an occasional case. Follow-up program consisted of observation and treatment of an occasional otitis externa, produced either by the irritation from the discharge or the drug itself. Such treatment was symptomatic.

It is impractical to use any of the commercial insufflators or powder blowers because of the physical properties of the drug itself. For this reason it was necessary to provide a means of adequately and evenly dispersing the powder in the ear. An ordinary one ounce, soft rubber ear syringe (sterilized) served this purpose to the best advantage. A hole was cut in the top of the bulb through which about a dram of the powdered drug could be poured into the syringe. The hole was closed with a sterilized soft rubber cork. The syringe thus prepared proved to be a simple and efficient insufflator.

A statistical table (Figure I) is presented to illustrate the results. This table distributes the cases over the number of days discharge exists, showing the number of treatments required and the number of cases involved. The interesting factor is that sixty-four of the eighty-four cases in the series, or 76 per cent, had no noticeable discharge in the external ear canal in seven days or less from the time treatment by the above method was instituted. The average number of days of the discharge was 6.16, and this included 61 per cent of the cases. Only 5.48 treatments were required in the average case until the discharge actually ceased. It is important to note here that in this entire series there was not a single instance of recurrence of the symptoms. No sequelae such as mastoiditis, labyrinthitis, salpingitis or the usual inflammatory conditions have developed. Several cases of otitis externa noted prior to the cessation of discharge promptly abated.

The series is graphically shown by Figure II. It can be noted that twenty cases, or 24 per cent, did not clear up in seven days or less. These are scattered over a time period from eight to eighteen days. Eleven of these twenty cases showed recovery

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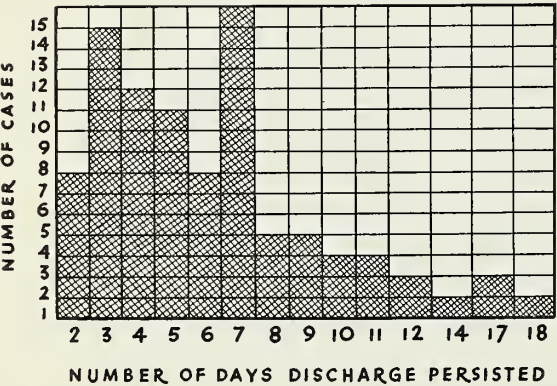
FIGURE I

Days of Discharge	2	3	4	5	6	7	8	9	10	11	12	14	17	18	Average Number Days of Discharge 6.16
Number of Cases	7	14	11	10	7	15	4	4	3	3	2	1	2	1	Total Cases 84
Number of Treatments	2	3	3.6	4.6	6	6.3	6	7.7	8.3	11	10	5	12	15	Average Number of Treatments 5.48

in ten days or less. Thus, seventy-five cases, or 89 per cent, of the total series attained the ultimate therapeutic goal in a time period of ten days or less. Nine cases remained infected from eleven to eighteen days. In every instance, however, complete recovery was accomplished.

The purpose of this report in no way tends to minimize the importance of hospitalization of patients suffering with acute suppurative otitis media, when the indications for such are apparent. Otologists have often emphasized the serious nature of this disease and its complications. It is even more important that the ambulatory patient be watched for sequelae. Each patient's complaints must be evaluated and the treatment afforded as indicated.

FIGURE II



Many investigators have shown the effects of the various sulfonamides and their value in the internal

treatment of middle ear infections. We have used sulfonamides, notably sulfathiazole and sulfadiazine, in connection with the local treatment in our hospitalized cases with markedly uniform results. These cases, however, can not be included in this report because of the additional therapy and care afforded them.

SUMMARY

1. During the period between December, 1942, and May, 1943, cases of acute otitis media constituted a major problem of the Eye, Ear, Nose, and Throat Department. Nearly 20 per cent of all treatments given through the out-patient clinic involved infections of the middle ear.
2. A report of eighty-four cases of acute suppurative otitis media treated locally by daily insufflation of sterile sodium sulfathiazole powder has been made.
3. This method of treatment afforded complete cessation of symptoms and discharge in an average of 6.16 days.
4. Eighty-nine per cent of the cases reported attained the ultimate therapeutic goal (recovery) in ten days or less.
5. The described form of therapy for acute suppurative otitis media proved effective in the limited number of cases (eighty-four) treated without developing any of the complications usually encountered in this disease entity.

(The able assistance and co-operation in this study by C. T. Clauson, P.A. Surgeon (R) U.S. P.H.S., and Justin Mignault, Assistant Surgeon (R) U.S.P.H.S., is hereby acknowledged.)

ARE YOUR 1944 DUES PAID?

SURGICAL TREATMENT OF VARICOSE VEINS

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INDIANAPOLIS

"Varicose veins of the extremities" probably has never been written on a death certificate. Because this disease is not regarded as a killer, it has not been given the attention nor treated with the respect which it deserves.

If we consider this disability in terms of the number of millions of man-hours lost, at a time when every able-bodied individual must do his utmost for the war effort, we are appalled by its seriousness. Those who have to determine physical fitness of individuals for our war industries are well aware of the percentage of persons who are unacceptable even for "sitting jobs" because of open varicose ulcers or such severe venous stasis that a breakdown is imminent. So far as is known, no nation-wide compilation of such disability has been made, but it would seem reasonable to estimate that nearly a million persons are now unfit for active duty in industry and for the war effort because of severe varicosities and varicose ulcers. To substantiate this estimate, the reject percentage of a local industry employing six thousand persons was checked. Slightly less than 1 per cent of those seeking employment was rejected because of severe varicose veins, and we may assume that individuals with severe conditions, such as open ulcers, did not apply for work.

Christopher states in his *Textbook of Surgery* that in a thorough examination of one thousand young healthy industrial workers, 10 per cent were found to have been affected with varicose veins.¹

Gerald H. Pratt, of New York, reported that 537 workers who had been in the employ of a large department store for fifteen years or more were carefully checked, and that 40 per cent of the men and 70 per cent of the women had varicose veins which were pathological and which were causing symptoms.²

It must be remembered that rejection for employment is only a part of our loss. With the present manpower shortage, persons with moderately severe varicose conditions are hired and placed on carefully selected work where they can be of some value; certainly they could accomplish more unhandicapped. Such workmen cannot be expected to put in the long overtime hours frequently demanded; during the present emergency many persons have worked twelve hours daily, seven days a week, and some plants have had to set up two twelve-hour shifts to keep vital machinery running.

We as physicians know well the effect on the venous system of a twelve-hour standing job. We do not have to be prophets to prognosticate a decided increase in venous disturbance of the legs, due definitely to our present demands for long hours at the lathe and workbench. The employment of great numbers of women in industry will further contribute to this increase.

If such disability is to increase, it behooves us to acquaint ourselves with all means of tried and proved treatment. Fortunately, due to the work of several large vascular clinics, where many thousands of patients have been treated and observed, and thanks to a few doctors who have been especially interested in this disease, we now have tried, proved, and safe treatment to offer the vein sufferer. It seems, however, that the majority of the physicians are not fully aware of the remarkably good results that can be obtained by proper treatment. But let us not condemn those who are skeptical, for of all the poorly and improperly treated diseases, the treatment of veins probably heads the list. Only a few years ago weird and horribly mutilating surgical procedures were carried out. Many types of sclerosing agents

FIG. 1



Typical varicose veins and varicose ulcer.

¹ Christopher, Frederick: *Textbook of Surgery*, page 168, W. B. Saunders Company, 1937.

² Pratt, Gerald H.: Results of Surgical Treatment of Varicose Veins, *J. A. M. A.* 122:797, 1943.

were used, with the general result that immediate improvement followed, but within a year or two the varicosities and open ulcers returned, and both the physician and the patient despaired of any chance of permanent cure. A surprisingly large percentage of physicians still tell patients that they know of no satisfactory treatment for varicose veins. These members of the profession should acquaint themselves with the results of high saphenous ligation *properly done*.

The history of the treatment of varicose veins goes back many years. Even as early as 500 B. C. varicose veins were recognized as a disease and were treated by puncture by Hippocrates.³ We probably owe to Trendelenburg our present concept of the cause and effect of hydrostatic pressure in the lower extremities and the subsequent formation of the varices. He was able to demonstrate his theory of back pressure in the saphenous vein by the use of a tourniquet placed at the uppermost part of the thigh, and this test is known as the Trendelenburg test. His work was done about 1891, and since that time many types of operations and treatments have been advocated, falling largely into four groups, namely:

(1) Section of the saphenous vein. This was easily and quickly done and usually consisted of picking up the main saphenous a few inches below Poupart's ligament and sectioning it. Probably the first high ligation approximating the modern type was done by Homans in 1916; however, it was not until 1930, or thereabouts, that DeTakats and others advised high ligation as done today, with the patient ambulatory.⁴

(2) Vein-stripping operations were introduced by Keller in 1905.³ Some did very extensive removal of the saphenous vein and branches below the knee; others removed the greater part of the vein above the knee, making use of a unique instrument called a "vein stripper."

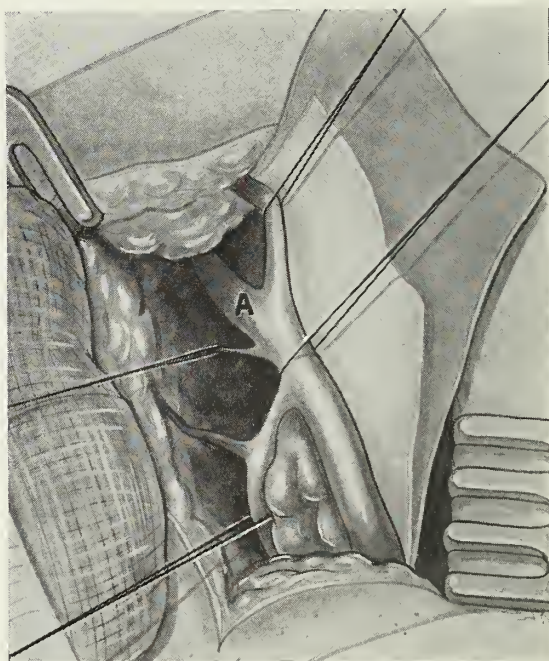
(3) A more formidable practice was the spiral incision, first introduced by Peterson in 1893.³ An incision was started at the upper thigh and extended to the ankle, circling the thigh and leg several times. For obvious anatomical reasons this was an effective way of curing varicosities, but it left a horribly mutilating scar.

(4) Injection of some sclerosing substance into the varices and into the branches of the saphenous vein. Many different types of substances have been advocated and quite a number have proved satisfactory. We do not wholly condemn this method of treatment, but we hope to demonstrate that injection treatment is woefully inadequate in a large percentage of cases. The criterion should be the Trendelenburg and Perthes' tests. If it can be demonstrated that there is a backflow from the deep circulation and from intra-abdominal pressure through the saphenous vein

to varicosities in the leg, injection treatment alone is seldom adequate to give permanent cure.

During the past several years peripheral vascular clinics have been established by many of our larger hospitals throughout the country, and thorough investigation of all methods of treatment has been carried out. The principles of treatment of varicose veins here presented were acquired from association with the peripheral vascular clinic of the Hospital for the Ruptured and Crippled (now the Hospital for Special Surgery) in New York City. In this clinic, as in many other vascular clinics over the country, the high saphenous ligation as first described by DeTakats⁴ was adopted as the proper method of treatment about ten years ago, and it has proved, beyond doubt, to be the only satisfactory means of treatment in the majority of cases.

FIG. II



(A) Saphenous trunk above all tributaries.

In approaching the treatment of varicose veins, the anatomy of the saphenous trunk should be carefully considered. The long or internal saphenous begins at the foot and ankle, receives tributaries from the inner side of the leg and thigh and empties into the femoral vein at the fossa ovalis, which is located about two centimeters below Poupart's ligament and lies about two centimeters medial to the femoral artery. This part of the vein, as it dips through the fossa ovalis to enter the femoral vein, we shall designate the saphenous trunk. It receives five distinct branches, some of which may be paired, namely: the main saphenous vein, the accessory saphenous vein, the superficial iliac circumflex, the superficial epigastric, and the superficial external pudendal. The

³ Harkins, Henry, and Schug, Richard: *Surgical Management of Varicose Veins, Surgery*, 11:402, 1942.

⁴ DeTakats, Geza: Ambulatory Ligation of the Saphenous Vein, *J. A. M. A.*, Vol. 94, 1194 (April) 1930.

short or lateral saphenous vein enters the deep vein in the popliteal space and drains the lateral side of the foot and leg. All of these branches enjoy a free anastomosis.

Trendelenburg was the first to present the logical explanation of the formation of varicosities. He pointed out that the saphenous vein is surrounded only by the skin and fatty tissues, and therefore the only support against acute dilatation is its own walls and its numerous valves. In contrast to this, the femoral vein is surrounded by heavy muscles whose every contraction compresses the vein, acting as a pump to force the venous blood up the leg toward the heart. The actual hydrostatic pressure may therefore be high in the deep veins without development of varices of the femoral vein because of muscular support. When the saphenous system begins to break down, one of two things, or perhaps both, happens: the valves themselves actually give away and break, or the wall of the vessel becomes weakened and dilates until the valves cannot meet. Either of these processes, or their combination, leaves the saphenous vein wide open with no means of checking the retrograde flow of blood. With man's upright position, hydrostatic pressure causes a constant backflow. Furthermore, intra-abdominal pressure at the time of any strain, such as lifting, coughing and defecation, is high and is transmitted to the well-supported abdominal veins, which in turn transmit this pressure wave down the veins of the leg. Where the vein wall is supported and the valves are intact, it is principally a pressure wave, but in dilated saphenous veins it is easily demonstrated as a definite, large-volume backflow. This may be shown by holding the hand over the upper part of the already dilated saphenous vein. If the patient is asked to cough, the vein can be seen to jump to sudden tight distention which recedes gradually as the blood flows on down grade toward the ankle.

There are numerous communicating branches between the superficial or saphenous system and the deep femoral system. These veins are well supplied with valves, and since they are surrounded by the large muscles they break down less frequently. By negative pressure in the femoral system the saphenous system can thus be sucked dry through the communicating branches. Though it may seem strange, this is the only way a varicose saphenous system is able to drain itself. If the valves fail to function, then we have the formation of a circular blood flow, the course of which is up the femoral vein to the dilated saphenous opening where a part of the volume leaves to enter the saphenous system and fall in retrograde course to the varicosities of the leg. It then again enters the femoral system through the communicating branches, and the process is repeated. The result is venous stasis, and in some cases such poorly created blood collects that the tissues of the skin are unable to subsist. It is then that we

have the formation of the varicose ulcer. It is therefore quite true, as well as logical, that a dilated saphenous vein is much worse than no vein at all. In proper ligation the saphenous system is completely obliterated and the superficial tissues are drained through the communicating branches directly into the femoral system.

The Trendelenburg test is done by raising the affected leg above body level, stroking over the engorged veins toward the body until they are collapsed, and then applying a tourniquet high in the groin. The patient then stands with the tourniquet in place. Usually the veins remain collapsed until the tourniquet is removed. If the test is positive, the saphenous vein can be seen and felt to distend the moment the tourniquet is removed; this is indicative of backflow from the deep system and indicates the need for ligation. In those cases where the short saphenous or a communicating branch is open, it can be found by putting the tourniquet at successively lower levels.⁵ Further information can be gained by digital pressure over what appears to be the broken-down communicating branch, and this may be further demonstrated by the use of Ace bandages wrapped both above and below the suspected point of breakdown. When present, these branches must be marked for ligation and sectioned separately.

The Perthes' test, which should always be done, gives the same information but also tests the patency of the deep circulation. In all post-phlebitis cases this is of great importance. When this test is done, the patient remains standing until the veins are fully distended. The high tourniquet is then placed and the patient instructed to bend both knees rapidly. Muscular action drives the blood in the femoral system upward, and with only a few contractions it usually sucks the varicose saphenous system empty, and it remains collapsed for some seconds until the high tourniquet is removed. If the saphenous vein is faulty, it distends rapidly upon removal of the tourniquet, as observed in a positive Trendelenburg test.

A further test of the deep circulation may be done by wrapping a tight bandage from the groin downward. If the deep veins are patent, no pain nor engorgement will result in the leg and foot, and none will develop even though the patient is asked to walk about for ten to fifteen minutes.

If the above tests are always done, there should be no risk in destroying the saphenous system, and in no case, either in those treated by the vascular clinic of the Hospital for Special Surgery, or in private practice, have we observed any damage to deep venous drainage following saphenous ligation.

Preceding ligation a general check-up and study of the patient should be done, as in preparing for any other surgical procedure. Those conditions

⁵ Adams, Ralph: Treatment of Varicose Veins and Varicose Ulcers, *Surg. Clin. of N. America*, page 933 (June) 1942.

predisposing to edema of the legs and ankles should be carefully considered, as it may be detrimental to interfere with the venous drainage in cases of elephantiasis, nephritis, cardiac decompensation or active phlebitis. In post-phlebitis cases, however, where the operation is definitely indicated, it should be done, and edema and swelling will diminish. Some chronic conditions affecting the feet and ankles, such as trophic ulcers, eczema and certain types of infections, may be greatly benefited by any treatment which relieves venous stasis. If the surgeon is undecided whether high ligation is indicated, a test treatment may be done by placing the patient at bed rest with the extremities level or in slight elevation. After a rest of ten days to two weeks, those conditions which will respond to venous ligation will have shown definite improvement.

It is not uncommon for a patient with severe varicose ulcers to give a history of having successively developed ulcers, gone to bed until they healed, had a few weeks of relief, only to repeat the process when the ulcer broke down again. Where we find such definite indication for treatment, a most gratifying result is expected from high ligation. Large ulcers will usually heal in from two to five weeks without special treatment or attention to the site of the ulcer. As typical of what may be expected in these cases, Mrs. A. had suffered from severe varicose ulcers of both legs for the past ten years. She had gone through the bed rest and recovery process and had received "leg shots" of an estimated total of one hundred seventy-five, from four or five different doctors. She was seen three years ago with large open ulcers of both legs, and high ligations were done. The ulcers healed and were dry within three weeks, with no local remedies applied. She became active with no swelling, enlarged veins or signs of ulcer breakdown. No treatment nor rest periods have been necessary since her surgery.

High saphenous ligation is considered by many as but a minor operation and not worthy of careful study. This conception no doubt has arisen because the procedure can be done under local anesthetic, it requires a hospital stay of only a day or two, the patient is ambulatory from the first, and the dissection is not deep nor extensive. However, high ligation is one of the more difficult surgical procedures if uniformly good results are to be obtained; furthermore, it is not without hazard and the surgeon should not feel properly qualified to expose the saphenous trunk without some experience and special study of the anatomy. Probably two or three hundred dissections are necessary before all of the peculiar types of variations in venous anatomy have been encountered, and it is this variation of the venous system which makes the operation difficult at times and which, in many cases, causes the surgeon to overlook important tributaries which later enlarge and cause the recanalization of the entire saphenous system.

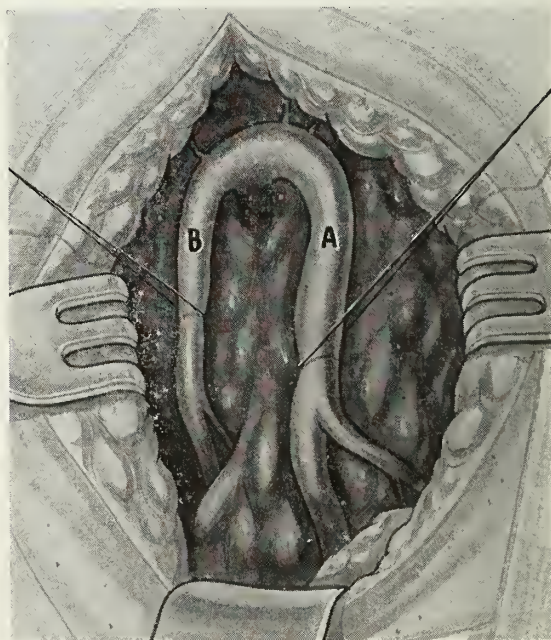
The three or four tributaries may converge to form one large trunk; in several cases the femoral circumflex with its descending branch has been found to be enormously dilated and to be the only vein found with incompetent valves. In such a case the veins may have the appearance of an inverted U (See Fig. 3). There are also cases on record where serious damage has been done to the femoral vein and even the femoral artery. Because of these factors greatest care should be used in handling the tributaries and the saphenous trunk; if even a small tributary is torn, startling hemorrhage results. If the trunk is torn at the fossa ovalis a very difficult situation is at hand, as the volume of venous backflow is unbelievable. Furthermore, the vein walls themselves often are thin, expanded, and very easily torn if undue traction is applied.

For a high ligation to be done properly, the saphenous trunk should be interrupted at the level of the fossa ovalis and above all tributaries. The following are the principal steps in the procedure:

(1) The patient should have the usual pre-anesthetic morphine before coming to surgery and should be prepared by having the groin shaved. The skin areas are then sterilized after the usual method.

(2) Two percent novocain anesthetic is used and is injected to permit an incision about three inches long, parallel to Poupart's ligament and with its center over the fossa ovalis. The location of the saphenous vein is determined as a point two finger breadths medial to the pulsation of

FIG. III



(A) Fairly normal saphenous vein.

(B) An abnormal enlargement of the descending branch of the superficial femoral circumflex vein.

the femoral artery and two finger breadths below Poupart's ligament. If the patient is slender the length of the incision may be reduced accordingly.

(3) The incision is then carried down through the superficial fascia, which is present as a definite fascial plane, and by spreading the fatty tissue beneath the vein is always found.

(4) Black silk should be used throughout; catgut may loosen or roll off the end of the severed vein.

(5) The small branches are tied with "C" or No. 1 Deknatel silk and sectioned.

(6) When the saphenous trunk has been unquestionably identified, two heavy Kocher clamps are placed about an inch and a half below the fossa ovalis and the vein is divided. By mobilizing the upper end of the saphenous vein it is much more easily dissected free from fatty tissue down to the opening of the fossa ovalis. A No. 2 black silk ligature is placed above all entering tributaries. This should be tied securely, then anchored through the vein wall. A second ligature should be placed in a similar manner. Firm ligation should be stressed more than any other part of the procedure.

(7) By means of a needle inserted through the vein wall, or, as some prefer, a canula or catheter introduced in the open end of the vein, 5 cc. of 5 per cent sodium morrhuate is injected. (Some

surgeons prefer to use larger quantities of the sclerosing agent.) A section of the trunk should be removed and the distal end ligated above the level of the entrance to the accessory saphenous. It, too, is doubly ligated.

(8) If the Trendelenburg test has given evidence of any faulty communicating branches or an incompetent short saphenous vein, the saphenous vein or branches then may be picked up very easily at the inner side of the knee, or at points indicated when the previously described tests were done, and sectioned. The skin is closed in the usual manner, using silk throughout.

(9) It is important that the patient be kept ambulatory.

SUMMARY

Varicosities of the extremities are among the commonest disabilities encountered by the physician, and we may expect an increase in vascular disease due to our present demands upon those employed in war plants. Where the Trendelenburg test is positive, the method of choice for treating varicosities of the lower extremities is high ligation and injection. The excellent results which can be obtained by proper treatment of varicose veins have not been fully recognized and are worthy of more general study by members of the medical profession.

ANESTHESIA OF PROTOPLASM

FRANK H. KELLY, M.D.

ARGOS

Much publicity recently has been given in lay journals concerning anesthesia of protoplasm (ice treatment). Very little seems to have been written in medical journals which would give the surgeon a detailed technique sufficient to enable him to proceed with an amputation.

The principle upon which the ice treatment is based is not a freezing process but one of chilling the protoplasm. When the temperature of the tissue is brought down to between 35 and 40 degrees Fahrenheit the activity of all protoplasm is inhibited. This is true of all cells, nerves, muscles and tissue cells—even the invading germs, themselves are inhibited. With this in mind it is easy to see why sensations of pain are not conducted to the brain nor is the central nervous system stimulated in any way that might produce shock.

Almost all metabolic processes are stopped. This is easily demonstrated by the fact that if a tourniquet is placed upon a guinea pig's leg for an hour, that animal will die in spite of anything that may be done to prevent it. If that same leg were packed in ice until the tissue were chilled and a tourniquet was applied in the same place and the leg kept

cold, the tourniquet might remain on from four to six hours without any bad effects. All of these facts should be well understood before attempting any amputations.

I understand that a chilling unit has been devised which eliminates the use of ice and makes the preparation and after-treatment of a limb much more convenient than packing with ice. This may be true, but most hospitals will do as I did and use ice for their first attempt rather than invest in expensive equipment.

In attempting to explain the method, I will briefly report the process followed in my first case, assisted by Dr. J. M. Alexander of Argos.

In November, 1941, Mr. J., sixty-four years of age, entered our hospital. He had diabetic gangrene of three toes on the left foot, with the black area extending along the side of the foot. The characteristic odor from this penetrated the whole hospital. He had had no previous treatment and his blood sugar was 468 mg. He was treated for a few days, being placed upon an approximate insulin balance. At seven o'clock on the morning of November 27, 1941, rubber sheeting was placed under

the leg; rolls of paper were put under the sheeting on each side to allow the melting ice to drain to the foot of the bed; chipped ice was then packed around the leg up to the knee; and eight rubber gloves filled with ice were placed over the leg. The site selected for amputation was about five inches above the ankle. After the leg had been in ice ten minutes, a tourniquet (rubber tubing clamped with an artery forcep) was applied tightly on the leg four inches above the site selected for amputation. A thermometer was then inserted in the ice next to the skin; some salt was sprinkled on the leg, and a temperature of two to three degrees centigrade was maintained for three hours, at which time the patient was given one-fourth grain of morphine and taken to surgery.

A sterile tourniquet was included in the surgical setup. When the leg was completely painted up to the tourniquet, it was removed; the skin under it was painted and a sterile tourniquet applied. The ice remaining on the table was covered with rubber sheeting; a sterile sheet was spread over the rubber sheeting, and the leg was placed thereon. A circular incision was made at the site selected and the amputation was performed in the usual manner. Outside of the ice, no additional anesthetic was used. It was thought that a circular amputation would give more even circulation to all flaps and thus aid healing; bleeding points were tied off with No. 1 plain catgut; the wound was closed with tension sutures of silk worm and skin clips; rubber cigaret drains were extended from either side to the

center of the stump; the patient was returned to his room at 11:30 A.M. and ate a regular dinner shortly after 12:00 noon. The ice was kept around the stump for three days, then gradually removed.

All pain ceased soon after the first application of the ice. There was no pain during the operation or afterward. The wound was dressed daily and the drains gradually removed. There was some drainage the first few days, but no shock, swelling or discoloration. No infection was present at any time and healing was by first intention but somewhat delayed; for this reason the stitches were left intact for two weeks, which seemed to help.

The blood sugar drops perceptibly immediately after amputation, and the insulin must be greatly reduced on the day of operation or insulin coma is liable to complicate matters. This happened to us in our first case.

The second case, one week later, was a man of fifty-seven years with diabetic gangrene. The history elicited and the technique used was about the same as in the first case. Amputations can be performed any place where ice can be packed and all the extra equipment needed to do the amputation is one hundred pounds of ice a day.

We are very enthusiastic about this method, for in my thirty years of practice about 98 per cent of our diabetics died following amputation, whereas now, with the anesthesia of protoplasm, 98 per cent are living, and the two first cases have been wearing artificial legs for over eighteen months.

RABBIT ANTISERUM AGAINST INFLUENZA A AND B VIRUSES FOR INHALATION PROPHYLAXIS AGAINST EPIDEMIC INFLUENZA

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Introduction. Publications during the last two years have indicated the inability of anyone thus far to secure a desirably strong degree of artificial active immunity against human influenza type A and B. Frequently, however, measurable amounts of various antiviral antibodies have been produced or increased in human beings by the use of influenza A and B virus vaccines, but immunity to the disease has lagged behind the early expectations.

The possibility that epidemic influenza is impending may leave little further time for perfecting more potent influenza virus vaccines. On the basis, however, of results already obtained in experimental local passive influenzal immunity in different parts of the world by Hare,¹ Stokes and

Shaw,^{2,3} Smorodintseff, et al.,^{4,5,6} Nachaev,⁷ Henle, et al.,⁸ Taylor,^{9,10} and Zellat and Henle,¹¹ current attention may be focused on preparation of high-titered rabbit antiserum against influenza A and B viruses, and use of this in large numbers of persons in a passive way by repeated nasal spray. This appears to be the only "specific" hope at the

² Stokes, J., and Shaw, D. R.: Production of Passive Immunity Against Influenza Virus by Introducing Immune Serums into the Respiratory Tract, *Am. J. Dis. Child.*, **58**:653-654, 1939.

³ Stokes, J., and Henle, W.: Studies on Methods of Prevention of Epidemic Influenza, *J.A.M.A.*, **120**:16-20, 1942.

⁴ Smorodintseff, A. A.: Experimental and Clinical Investigation of the Specific Prophylaxis and Therapy of Influenza by Inhalation of Immune Serum, *Proc. Third Inter. Cong. of Microbiol.*, N. Y., p. 375, 1940.

⁵ Smorodintseff, A. A.; Gulamow, A. G., and Tschalkina, O. M.: Specific Prophylaxis of Epidemic Influenza by Inhalation of Antiserum, *Zeit. f. klin. Med.*, **138**:756-765, 1940.

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¹ Hare, R.: The Effect of Passive Immunization on Experimental Virus Influenza in Mice, *J. Path. and Bact.*, **49**:411-428, 1939.

moment, and use of such antiserum passively in humans, for economy of serum, would be reserved for times at which influenza begins to become epidemic as judged by appearance of initial cases in the community.

This "local" use of antiserum in the trachea, bronchi, et cetera, appears to block off and neutralize incoming influenza virus experimentally much better than almost any attainable amount of circulating systemic antibody. Antiviral serum spray in influenza in some ways, therefore, resembles the well-known local use of sulfonamide powder, et cetera, in bacterial infection, and needs little comment as to mechanism of action or immunological background. Suffice it to say, however, that high-titered serum antibodies present in quantity in the respiratory epithelium shown by Straub¹² to be most vulnerable to the destructive action of influenza virus may be expected to be maximally effective, while antibody in tissues remote from the limited site of specific injury would appear almost entirely superfluous. This seems likely also from the studies on local bacterial respiratory immunity of Walsh and Cannon.¹³

In this report we wish to present the technique of experimental influenza A and B virus production and its adaptation to intravenous immunization of rabbits in the preparation of high-titered antiserum. We are greatly indebted to Frank L. Horsfall, Jr., M.D., of the Rockefeller Institute, for his original recommendation to undertake this work, also for his continued advice in the course of the work during which many lots of this antiserum were tested by his laboratory.

Growth of the viruses. Influenza PR8 type A and Lee type B viruses as supplied by Dr. Horsfall were grown forty-eight hours in the allantoic fluid of eleven-day incubated eggs in the usual way. At

this time the virus-containing allantoic fluids were drawn off aseptically from each egg and placed in tubes in ice water. About four to eight or nine cubic centimeters of virus-infected fluid were obtained per egg. These fluids were proved free of bacteria by rapid microscopic examination of gram-stained smears. All virus-containing fluids of each type were pooled and small samples withdrawn for prospective intranasal virulence tests in half-grown Swiss mice, and hemagglutination tests.

Since repeated intravenous injection of rabbits with allantoic fluid virus in the raw state directly from the egg leads to anaphylactic shock of the animals at the third to the fifth dose, we purified and concentrated the viruses intended for injection by adsorption and elution on embryo chick red blood corpuscles as described by Francis and Salk.¹⁴ By this technique approximately 2 per cent emulsions of chick red blood corpuscles were mixed with the allantoic fluid virus, and these emulsions were chilled at 4° C. for two hours. The red cells in most cases agglutinated quite rapidly. Centrifugation was then done in the cold, the supernatant fluid, containing small amounts of unadsorbed virus plus inert chick protein, urates, et cetera, was discarded, and the red blood corpuscles, with adsorbed virus, were resuspended in a half volume of fresh sterile saline. The fresh saline suspensions were placed at 37° C. for two hours to facilitate elution of the virus from the red cells. At this temperature the cold virus-agglutinated red cells "unagglutinated" and redispersed. The virus dispersed also. Centrifugation was again done and the supernatant virus-containing fluid was saved, and the sedimented cells discarded. Table I shows the intranasal potency for Swiss mice of a representative type A allantoic fluid influenza virus in the raw state, and in the purified state following routine adsorption and elution. It is observed that a high percentage of the virus was successfully adsorbed out of the raw allantoic fluid

⁶ Smorodintseff, A. A., and Shishkina, O. I.: I. The Role of the Humoral Factor in the Mechanism of Active Immunity Against Influenza, *Arch. f. d. ges. Virusforsch.*, **2**:156-174, 1941.

⁷ Nachaev, A. V.: The Evaluation of the Effectiveness of Specific Serotherapy by Inhalation of Anti-influenzal serum, *Soviet Med.*, **7**:25, 1940.

⁸ Henle, W.; Stokes, J., and Shaw, D. R.: Passive Immunization of Mice Against Human Influenza Virus by the Intranasal Route, *J. Immunol.*, **40**:201-212, 1941.

⁹ Taylor, R. M.: Experimental Infection with Influenza A Virus in Mice, Increase in Intrapulmonary Virus and Factors Influencing, *J. Exp. Med.*, **73**:43, 1941.

¹⁰ Taylor, R. M.: Passive Immunization Against Experimental Infection of Mice with Influenza A Virus, Comparative Effect of Immune Serum Administered Intranasally and Intra-abdominally, *J. Immunol.*, **41**:453-462, 1941.

¹¹ Zellat, J., and Henle, W.: Further Studies in Passive Protection Against the Virus of Influenza by the Intranasal Route, *J. Immunol.*, **42**:239-249, 1941.

¹² Straub, M.: The Microscopical Changes in the Lungs of Mice Infected with Influenza Virus, *J. Path. and Bact.*, **45**:75-78, 1937.

¹³ (a) Walsh, T. E., and Cannon, P. R.: Immunization of the Upper Respiratory Tract, *Arch. Otolaryngology*, **20**:820-836, 1934.

(b) Walsh, T. E., and Cannon, P. R.: Immunization of the Respiratory Tract, *J. Immunol.*, **35**:31-46, 1938.

TABLE I

INTRANASAL POTENCY TESTS OF INFLUENZA A VIRUS IN SWISS MICE (EACH MOUSE RECEIVED A DOSE OF ABOUT 0.02 CC. OF VIRUS DILUTION UNDER LIGHT ETHER ANESTHESIA)

<i>Virus dilutions in sterile broth</i>	<i>Raw allantoic fluid virus direct from egg with no treatment</i>	<i>Virus purified by adsorption on red cells at 4° C. and elution off in fresh saline at 37° C.</i>
5×10^{-2}	4, 5	5, 5
10^{-3}	5, 5	6, 7
5×10^{-3}	6, 6	5, 6
10^{-4}	7, 7	8, 8
5×10^{-4}	7, 7	8, 10
10^{-5}	7, 10	S + + +, S + +
5×10^{-5}	S + + +, S + + + +	S + +, S + +

Each figure indicates day of death of a Swiss mouse; S indicates survival 14 days, and + to + + + + indicate increasing extent of lung consolidation found at autopsy.

¹⁴ Francis, T., and Salk, J. E.: A Simplified Procedure for the Concentration and Purification of Influenza Virus, *Science*, **96**:499-500, 1942.

and eluted off into fresh saline for further use. Type B virus processed by the same technique, as is well known, is somewhat weaker in the raw state and also in the purified state following adsorption and elution.

Immunization of rabbits. Full-grown animals were given weekly intravenous injections of 5 cc. of the above purified A and B influenza viruses mixed in equal parts. These doses were well tolerated, and no symptoms of shock appeared except in a few instances when slight hemolysis of the adsorbing red cells took place in preparation of the virus for injection, and the purified virus had a slight hemoglobin tinge. It may be added that rabbits are quite resistant to living influenza virus (which is virulent for the few most susceptible species, including humans, only when given intranasally).

Following six weeks of immunization, rabbits treated as described have produced antiserum of a titer of 1:4096 against both influenza A and B viruses. These tests comprise inhibition of virus hemagglutination of chick red cells as reported on by Hirst.¹⁵ Eight 50 per cent hemagglutinating units of virus were used as test doses with various dilutions of serum. As stated previously, we are obliged to Dr. F. L. Horsfall, Jr., for conducting most of these potency tests. Continued rabbit bleedings made weekly or bi-weekly have exhibited titers of 1:2048 to 1:8192, and immunization was continued weekly.

All routine rabbit bleedings were allowed to clot, then were chilled and centrifuged, and the clear serum was drawn off and heated at 56° C. for thirty minutes. 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate) 1:10,000 was added as a preservative, and the antiserum was then filtered and proved sterile by proper culture tests. Finished antiserum was filled into 20 cc. vials and stored at 4° C.

Indications for use of antiserum. Briefly, it is suggested that prompt prophylactic (not thera-

peutic) use of the antiserum by nasal spray be started in persons likely to be exposed, and that this be done only after initial influenza cases have appeared in the community or adjoining areas. About 1 cc. of antiserum should be used per person, 0.3 cc. being sprayed into each nostril, and 0.3 cc. sprayed over the fauces (the average bulb atomizer delivers about 0.1 cc. at one discharge). In case no atomizer is available, medicine droppers can be used, but these are not quite as satisfactory as atomizers in securing proper distribution of serum.

Inhalation antiserum should be given as described once weekly for four weeks. If new cases are still appearing at this time, the prophylaxis should be continued for a week or so after the last cases of influenza have appeared in the community.

The recent results published thus far of experimental tests with antiserum against influenza virus in various parts of the world indicate that high-titered antiserum administered in this way is efficacious as a prophylactic agent. There is no proof that such local passive immunization by inhalation of antiserum has any therapeutic action in cases after influenza infection is present. Preparation of the influenza antiserum described above was intended for as wide use as possible if and when epidemic influenza appears. Obviously, at the moment this is a research item and not a commercial product. The probable explosive onset of the next wave of epidemic influenza, likely to overrun a contemporary publication, makes this preliminary report appear advisable.

SUMMARY

1. Recent medical reports dealing with epidemic influenza antiserum for use by inhalation have been reviewed.
2. Methods of preparation and purification of influenza A and B viruses for immunization of rabbits to prepare this antiserum are described.
3. Indications for passive prophylactic use of high potency epidemic influenza antiserum by intranasal spray are set forth.
4. Limitation of use of this antiserum to prophylaxis on a wide scale slightly in advance of appearance of cases in epidemic numbers is advised.

¹⁵ Hirst, G. K.: The Quantitative Determination of Influenza Virus and Antibodies by Means of Red Cell Agglutination, *J. Exp. Med.*, **75**:49-64, 1942.

OFFICIAL MEETINGS IN JANUARY:

January 9—State Council Meeting
January 23—School for Speakers
and
Annual Secretaries' Conference

THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL
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JANUARY, 1944

Editorials

MAY THE NEW YEAR BRING
VICTORY AND PEACE

**THE SECRETARIES-EDITORS'
CONFERENCE**

The annual conference of secretaries of state medical associations and editors of state medical journals was recently held at the A.M.A. headquarters, in Chicago, with an unusually large attendance and with an interest seldom observed in these annual gatherings. It was patent that this group of medical men, men who have much to do with the shaping of medical policies, had in mind the seriousness of the situation that presently confronts the medical profession, and that they were seeking a solution to its many problems.

As is stated in another editorial in this issue, Major General Lull, Deputy Surgeon General of the United States Army, made one of the principal addresses.

Drs. Paullin, president of the American Medical Association, and Kretschmer, president-elect, also

addressed the meeting. Dr. Paullin reviewed the work of recent years, while Dr. Kretschmer discussed some of the problems at hand and their possible solution. The latter made the point that Public Relations in medicine is quite different from that in industry; the approach is through a different channel. He is opposed to common Public Relations in medicine. His talk, in the main, may be said to have been a defense of the American Medical Association, its officers, bureaus, et cetera.

Later in his talk he restated that he believed the best defense against the Wagner-Murray-Dingell Bill was a personal one, wholly differing from a statement made subsequently by another A.M.A. official to the effect that headquarters had prepared to send out every available man on a speaking campaign. In addition to men from the official family, every state organization would be asked to supply such speakers.

Later on in the meeting the matter of medical enlistments was brought up, and the flat statement was made that there still were a few doctors under the age of thirty-eight years being inducted as privates because they had refused to enlist in the Medical Corps. Concerning the relocating of physicians, it was stated that as of November fifteenth some fifteen hundred physicians had been transferred to areas where the civilian need was greatest.

Dr. Bauer, chairman of the recently organized Medical Service Council, made a report of the organization of that group. He stated that the Council has definite functions, but that until the new secretary begins his work, as of January first, little can be done. The newly-appointed secretary of the Council is Dr. George L. Kelly, dean of the University of Georgia School of Medicine. Dr. Bauer stated that the Council would first study all the systems of medical care that had been proposed and that the Council approves of *voluntary* medical insurance. However, it seemed that Public Relations, as the term is commonly understood, will not be a prominent part of the current picture, even though the 1943 A.M.A. House of Delegates seemed to have that item in mind when the Council was brought into being.

The second day of the conference was devoted to economic matters, the Michigan plan being presented and thoroughly discussed.

On Friday evening the annual editors' dinner was held at the Palmer House, an overflow crowd being present. Dr. Wingate Johnson, of Winston-Salem, North Carolina, presided. There was no formal program for this meeting, the evening being devoted to a discussion of the work of the Council on Pharmacy and Chemistry, and the Co-operative Medical Advertising Bureau. Dr. Smith, secretary of the Council, presented a review of some of the duties of the Council, outlining its many activities and in particular explaining why there is an occasional delay in a final decision, also why certain articles generally used by the members of the profession are not "Council accepted."

In the discussion of matters concerning the Cooperative Bureau, it was made clear that many state journal officials felt that something should be done to assure more advertising for these publications; some going so far as to declare that they contemplated having their own publication committee, a system practiced by some few state journals at the present time. Others felt that the Bureau should be more "on its own," that perhaps there were some features in the present plan that might well be eliminated and that some new measures might be instituted. During the two-day session personal conversations with editors, managing editors and other officials made it clear that there was more than an undercurrent to this effect. The committee in charge of the Bureau was recently enlarged, two new members — medical journal editors — being added, and it is hoped that the newly reorganized committee may bring about some of the desired changes.

Several in attendance made bold to suggest that it might be well, in planning the program for future sessions, to have a program committee composed of state secretaries and editors in charge of program arrangements, that such a plan probably would bring up for discussion more subjects directly connected with the two groups. However, we have attended our twelfth such gathering and have found them universally interesting and informative.

MORE ABOUT THE MEDICAL CORPS

At the recent Secretaries-Editors' Conference, held in Chicago, Major General George F. Lull, Deputy Surgeon General of the United States Army, had much to say about the accomplishments of the Army Medical Corps, his remarks being of the first-hand variety. According to General Lull, this group is acquitting itself in handsome fashion.

He related incidents that have occurred in the South Seas area and elsewhere, in which medical men have had to resort to the most extreme emergency measures, likening their duties in many ways to the routine of the country physician.

He also stressed the point that warfare in the South Pacific is far different from that being waged in Africa, Italy, and other European areas; that the medical and surgical problems are in no wise the same in the two regions. In the South Seas malaria is our greatest enemy, said General Lull; it usually does not kill, but it does take men out of combat.

"Blood plasma is a godsend," said General Lull; it is saving thousands of lives. Later on the General made the declaration that the American soldier is getting far better care than that to which he was accustomed at home. (Not that Medical Corps officers are better physicians, but that soldiers are taught to respond to sick call when they feel a bit "off.")

General Lull classified the physicians of America into four groups:

1. The men now in service.
2. Men too old to be accepted for service.
3. Men essential to civil life.
4. Men who are eligible but show no interest in enlisting.

The above is a good classification, as we view it; one need have no trouble in placing himself in the proper niche!

Another aphorism is, "Physicians in the Army generally find their level." Some complaint has been registered by Medical Corps men that their assignments are not to their liking and not according to their capabilities. According to General Lull, these discrepancies soon are ironed out and the man finds himself in his proper level.

In speaking of the malaria problem, he cited instances where recent landing parties did not have their mosquito nets at hand for a night or two, with a resultant high incidence of malaria in that group.

"We of the Surgeon General's Office still have a lot of headaches, the hospital intern situation being a most potent cause thereof. However, the new 'intern plan' is working out nicely and the matter soon will be properly adjudicated," he said.

The need for several thousand more medical officers still confronts the American Army, and just how this need is to be met continues to constitute a big problem. The Surgeon General is fully aware of the needs for medical care in civilian life, yet he feels that adjustments can be made here and there over the country that will bring into the Medical Corps the needed increase in personnel and yet not too seriously disturb the civilian balance. The declaration was made that from 5,000 to 7,000 additional medical men are needed — must be had. "We *can* get along with 48,000 to 49,000 doctors," said General Lull.

Before our entrance into the present global war, there were some 1,500 medical officers in the Medical Corps; we now have more than 40,000.

Here then is the picture of what American Medicine has done, and is doing, as its contribution to the war effort. It is a beautiful picture, as pictures go, but we should look beyond a "picture." A great majority of the able-bodied physicians of the nation are in service at the present time; practically every new graduate is automatically inducted into that service. American Medicine should and does hold its head erect — high, if you please — since we are doing things in the American way.

It is true that there still are some who should be in service but who have taken advantage of every slight excuse to remain at home. It is our belief that this small group will ultimately be "smoked out," perhaps by legislative action, perhaps by pressure from local medical groups, or perhaps by publicity.

As we have said, the address of General Lull was most informative and indeed refreshing. From

headquarters we are advised that we are doing our bit, and doing that bit in a most exemplary fashion. It would seem that we have an additional weapon in our fight for medical freedom.

THE OLIVER GENERAL HOSPITAL

Indiana Medicine takes much pride in the fact that this institution, opened at Augusta, Georgia, a few months ago, bears the name of an Indiana World War I veteran, Robert Todd Oliver, Chief Dental Surgeon in that war.

Hoosier-born, Doctor Oliver was ushered into the world at Indianapolis, on January 25, 1868, the son of Dandridge Holladay and Theresa Jane (Hedderly) Oliver. He had two citations from France as a result of his work in that country during the war, one being the "Legion of Honor."

Under General Orders No. 103, War Department, 1919, he was awarded the Distinguished Service Medal. He displayed remarkable ability in the performance of his numerous and exacting duties. He directed the personnel, equipment and operations of his department with sound judgment, showing resourcefulness in solving new problems which confronted him.

Doctor Oliver served as Professor of Oral Surgery at the Indiana Dental College for many years, and in his private practice was generally regarded as an outstanding authority on the subject of dental surgery.

In 1898 he entered service, via the Indiana National Guard, and served during the Spanish-American War. He re-entered service in 1901, serving in the Philippine Insurrection, and later with the Punitive Expedition into Mexico.

He was commissioned as dental surgeon in 1911; Captain, Dental Surgeon, in 1916, and as Colonel, Dental Surgeon, in 1917. He served overseas from July 28, 1917, to August 29, 1919. He is still in service.

Thus does the War Department pay a lasting tribute to another Hoosier professional man, one who richly deserves such a reward. Colonel Oliver served Indiana dentistry for many years, during which time he added no little to its store of knowledge—during his long years of service he has added to that accomplishment. We may well feel proud of the recognition that has come to this man and to our state.

SELF-PRESCRIBING

Under the title, "People Love Their Medicines," the editor of the *Muncie Press* voices some worthwhile opinions. He seems intrigued by the manner in which the American people have taken to their vitamins. Sagely, he remarks, vitamins have a definite place in modern therapy but should be used on the advice of the family physician. However, too many folk, having read in the daily press and in their favorite magazines of vitamin this and vitamin that, proceed to the corner drug store to purchase large quantities of these agencies.

The editor proceeds to recall some former days, days when "teas" had their vogue; later, it was "blood purifiers," usually taken in the springtime when the blood was supposed to be thick and needed a thinning out. Sassafras bark, indigenous to Indiana, was one of the most commonly used teas for this purpose. (In our Wild Cat youthful days we had this every spring, and even yet, come the balmy March days, when we see bundles of this root displayed in the local groceries we buy a bunch or two and for a few days enter into the blood thinning program.)

Sarsaparilla, another flavorful root, was used by many, and its popularity no doubt led an easterner, C. I. Hood of Massachusetts, we believe, to formulate a compound, selling at a dollar a bottle, which was known from coast to coast. In driving through most any section of the country one met the Hood signs, usually painted on the sides of the barns throughout the nation. As we recall it, this was the most popular patent medicine of its age.

We believe we are correct in the statement that this advertising success was directly responsible for the era of patent medicines which soon followed. "Headache remedies" began to appear in every section of the country, these depending chiefly on acetanilid for their results. In Indiana there were few county-seat towns which did not have a "headache remedy" business.

Then came the "bitters," concoctions that seemed to contain about everything that possessed a strong acrid taste, plus a goodly percentage, often as much as fifty per cent, of varying grades of Bourbon liquor. These potions were not hard to take, and their sales, particularly in "dry" territory, rose by leaps and bounds. Many a good old prohibitionist-voting churchman had his daily dose, or doses, of "bitters."

The Muncie editor sums it up this wise: "But the American people love to take a chance and doubtless will continue to do so, whether it be a new vitamin or a new type of some other commodity."

First, of course, the blame is to be laid at the door of the medical profession for having fostered the idea of self-drugging. Over the telephone and in the office the medical man says, "Go to the drug store and get this." The purchase is made, and

FOR VICTORY

BUY WAR BONDS AND STAMPS

if the buyer thereof feels he has been benefited, he tells his friends who essay a similar program.

Numerous instances might be cited to substantiate this point. Go back to the early days of quinine sulphate; old timers have told us of its introduction to modern therapy. It was not sold over drug counters in the indiscriminate fashion of today — of course in this wartime quinine is not to be had for the asking.

A second cause of self-drugging, and the most important, is the advertising campaigns carried on over the radio, which blatant blaring is a daily sequence of advising self-drugging.

It is little wonder that Morris Fishbein predicted in a recent address that the enrichment of natural foods with vitamins would increase in the future, but he described the "promotion and sale of vitamins as a one-hundred-million-dollar-a-year industry."

And, as medical men well know, the indiscriminate dosing with vitamins too often is to the detriment of the health of the patient; this being especially true in the "shot gun" variety of vitamin content. After all, such an important addition to our therapeutic list should be used with due care, which means on the advice and under the supervision of the physician.

Editorial Notes

The date for the mid-winter meeting of the Council has been set for January ninth and promises to be of epoch-making proportions. Many of the present-day medical problems will be threshed out at this session, the most important Council meeting of the year.

Doctor R. L. Shriner, head of the Department of Chemistry of the Indiana University Medical School, in addressing a luncheon group recently commented on the quinine shortage. He stated that while there are synthetic substitutes for the treatment of malaria, they are not as satisfactory as might be desired, and that the research chemists still are seeking a better compound.

The *Indianapolis News*, in an editorial headed by the euphonious title, "Ol Doc Bureaucrat," comments on the proposed Wagner-Murray-Dingell legislation, and in conclusion uses the following apropos statement: "If the Wagner medical care Act should pass, and the Washington totalitarians run true to form, Ol' Doc Bureaucrat would need only about five years to get control. And the medical charts would start out with what would then be the most important question—'How did you vote last time?'"

Penicillin continues to share the spotlight with several other new means of therapy, its use in many instances seemingly bringing about results of the miracle type. Post-war study of this substance will no doubt find many new uses, and its development will be watched with unusual interest.

Dr. Harry L. Smith, of the Mayo Clinic, recently described coronary sclerosis as being a "disease of the intelligentsia," because of its high incidence among physicians, lawyers and clergymen. We long had known this to be the "doctors' disease"; now it seems we must share it with the other professions.

The Welborn-Walker Hospital, Evansville, has been sold to the First Baptist Church of that city, by Dr. James Y. Welborn. The church will henceforth operate the hospital. The original Walker Hospital was opened in 1893, by Drs. Edwin Walker and A. M. Owen. Dr. Welborn became associated with the institution in 1899 and for many years past has been the directing head.

Mention was made some time ago of a plan adopted by the Mount Vernon medical group in the matter of Sunday hours. They hit upon a plan of having one man taking care of Sunday calls, thus enabling the other physicians to have one day of rest. That the plan still is in operation is evidenced by the publication of the schedule for the balance of the year.

The present epidemic of "Flu" which seems to be sweeping our section of the country has added materially to the civilian medical care problem. Numerous physicians have been the victim of the malady, thus adding to the already heavy burden of other at-home physicians. It is noted that much of the present epidemic is of the "head cold" type, and that complications of pneumonia are not so frequent as during the siege of World War I. It also has been suggested that the present mild type may serve as an immunizing agent, preventing later and more serious infection.

We occasionally come across a press clipping announcing an increase of medical fees by Indiana physicians. Why not? We pay "right through the nose" for everything we eat and wear; our drug and supply bills are ever on the increase; in fact, the increased cost of living hits the doctor in just the same manner as it hits every other citizen. We note that in one county the physicians have increased day calls *from two dollars to three dollars*. We had no idea that any Indiana physicians were making calls for a two-dollar fee in these times!

Twenty-two nurses have recently completed the special course in psychiatric nursing at the Logansport State Hospital, and another class of twenty-seven has entered the same training. This is in line with the suggestion that has been made to the effect that psychiatric care for an ever-increasing number of servicemen is one of our war problems. Nursing service of this type demands special training, and we are pleased to note that Indiana, as usual, is in the forefront in the matter.

Hoosier folk can now sit complacently while listening to the complaints of residents of our neighboring states, while they moan over the tax bills incident to paying for the hard roads which were built via the bonding system. Indiana takes a back seat to no other state in the matter of mileage and quality of her road system, and every dollar paid for these roads has been paid in cash. Every so often we like to take a moment's time to thank those of our forefathers who, in building the Constitution of our state, inserted that clause whereby the state should have no bonding power.

Dr. Paul D. Williams, superintendent of the Richmond State Hospital, recently is quoted as saying that the average cost of caring for mental cases in this state is sixty cents per day. Much of the credit for this low rate is due to the fact that in most of our state hospitals the patients raise the greater part of the food, particularly vegetables which are processed at the hospitals. In 1939, according to Doctor Williams, there were some 900,000 hospital beds in this country, of which some 500,000 were occupied by mental cases. About 20 per cent of the inmates are improved enough to return to their homes, and 13 per cent are regarded as cured.

The legislative committee appointed by the 1943 General Assembly to investigate the need, and perhaps the location, of an additional hospital for crippled children has been active in their duties. Several meetings have been held, chiefly in the northern sector of the state where the proposed hospital probably would be built in case such a plan finally materializes. We believe that this committee is approaching the matter in the proper manner. They are conferring with medical, welfare and other groups, seeking the information necessary to a clear picture of the situation. Just now the state of Indiana is sitting pretty in the matter of finances; we have a large cash balance and, of course, no bonded indebtedness. But having the money on hand does not mean that we should be in any great rush to spend it. However, if the committee investigation reveals a crying need for additional hospital facilities for the children of our fair state, we know of no better place to spend some of that surplus.

The annual meeting of the American Medical Association will be held in Chicago, June 12-16. At the last meeting of the House of Delegates it was voted to hold this meeting in Saint Louis, but investigation reveals that hotel facilities in that city will be inadequate at that time. The House of Delegates will meet in the Palmer House, which also will house the Scientific Exhibit. The technical display will be in the Stevens Hotel.

Right off the bat we begin our annual plea for the prompt payment of your annual dues; this year, more so than in former years, this is very important. Your local officers are busy, busier than in many years, and do not have any extra time to look after dues collections. Prompt payment will also expedite matters at headquarters and, as you well know, we all are trying to save time.

Victory Garden operators of last summer now are cashing in on their efforts via the dinner table. Thousands of Hoosiers, many of them for the first time in their lives, are sitting down to a table covered with foods which they themselves produced and processed. And it seems that plans for 1944 will outdo all previous efforts. Seed stores report that orders for seeds and plants are being received in greater number than ever before. Our latest food-production plan is the provision of a supply of old-fashioned Hoosier hominy for our table. We finally located a workable recipe, then found the main problem was to get the white corn. This we finally located, and we hope to get into production at an early date.

The "nursing home" situation in Indiana has become a problem as a result of the legislation enacted by the 1943 General Assembly. For one thing, members of the legislature sought to make such homes safe for the inmates thereof, setting out certain safety regulations of such nature that many of these homes cannot comply with them. According to an Indianapolis judge, Federal interference has much to do with the complexity of the problem. It seems that genial Uncle Sam, in providing an allotment for the inmates of these homes, has demanded the right to make rules and regulations under which these places must operate. In other words, it is just another case of official Washington having set aside money for a certain purpose, to seek control of the spending of that money. That of itself probably is all right; we agree that appropriated monies should be properly and wisely spent, but the mere fact that such dollars have been appropriated does not carry the right of some Washington bureau to control the institutions receiving those awards.

The *Evansville Press* takes occasion to comment on the activities of some members of the legal fraternity now engaged in wartime service. The article refers to the lawyers working right alongside the members of the Medical Corps in our Army hospitals, "to speed the recovery of wounded soldiers by giving them free advice on financial problems and other perplexing difficulties." This work is carried on by both men from the office of the judge advocate and by volunteer groups from some of our state bar associations.

The Annual Secretaries' Conference will be held in Indianapolis on January twenty-third, the preliminary program of which seems to indicate a meeting of more than usual importance. These annual meetings have grown in character and scope until now they are looked forward to by several hundred Indiana physicians interested in furthering their profession. In addition to local attendance we have numerous guests from without the state, most of whom have heard of what goes on in Hoosier Medicine on this occasion. The complete program appears in this number of THE JOURNAL, and it should be borne in mind that the meeting is open to every doctor in our membership.

The Council of the Lake County Medical Society has addressed the following letter to the proper health officials with whom the matter is concerned. As stated, it is the opinion of the Council that such matters are of the privileged communications sort and should not be "broadcast," as apparently is being done in at least one section of the state:

"At its meeting on December 5, 1943, the Council of the Lake County Medical Society was given a list of pregnant wives of members of the armed forces, which had been furnished to the public health nurse of the city of Gary with a request that she call upon these women.

"It is the opinion of the Council of the Lake County Medical Society that the fact of pregnancy is privileged information between physician and patient, and the fact that federal assistance is requested for the pregnant wives of service men should in no way throw open to the Public Health Department or others this information. Numerous reasons were cited by the members of the Council that the pregnant wife of a member of the armed forces might have reasons for desiring to maintain secret the fact of her pregnancy from those with whom she resides or from employees of the local health department.

"It is further believed by the Council of the Lake County Medical Society that the physician through whom the request for assistance was made is entirely competent to make whatever recommendations regarding her pregnancy are necessary without the assistance of the public health nurse.

"The Council of the Lake County Medical Society therefore protests this procedure and requests its immediate discontinuance, except in those cases where the assistance of the public health nurse is individually and specifically requested either by the patient or the attending physician."

Have you taken a moment to thank the editor of your local paper for his stand in the matter of the Wagner-Murray-Dingell Bill? From the clipping service coming to THE JOURNAL, it would seem that practically every paper within the state has at one time or another taken a definite stand against this proposed legislation, and these papers are read by a great majority of the folk with whom you come in daily contact. It would be well to take a few moments to talk with your editor; thank him for his cooperation and make suggestions for further articles along the same line. It is this sort of a campaign that will do more for us than any other; it requires no extensive planning and can be carried on right in your own community.

The following editorial is reprinted from the *Indianapolis Star* of November twenty-fourth and merits reprinting:

NON-POLITICAL MEDICINE

"Tactics typical of the political demagogue were employed by Senator Murray, co-author of the Wagner-Murray social security and health insurance bill, to discredit members of the medical profession battling to save this country from further New Deal socialism. Speaking at a New York symposium, Senator Murray charged that the American Medical Association had joined with companies specializing in 'quack medicines' to defeat the bill. He also accused leading pharmaceutical houses of contributing funds to fight the administration's efforts to impose the blight of state medicine on the nation.

"Pamphlets endeavoring to educate the public, according to the New Deal senator, were 'definitely aimed to excite prejudice and fear.' Murray knows that thinking citizens familiar with the perils of the social security measure will demand its defeat. It would establish a new bureaucracy controlling every person requiring medical care and making the country's physicians the helpless pawns of political regimentation.

"The Wagner-Murray extension of social security uses the favorite New Deal tactics of starting with government handouts and ending with Federal control. The misleading propaganda in favor of the program emphasizes the wholly admirable purpose of making medical and health care available to all. Specious theories lose their appeal when details of the proposal are investigated.

"The plan would place in the hands of the surgeon general the spending of more than \$3,000,000,000 from annual compulsory pay roll deductions. Medical men warn that, because the sum is so huge and because it would employ so many doctors and include so many hospitals, it would mean the control of medical and hospital facilities by the Federal government.

"There is nothing unethical in the acceptance of financial contributions from medical associations and pharmaceutical houses in opposing this costly extension of government paternalism. The misinterpretation of which Murray complains is really a patriotic service which such organizations are rendering in supplying funds to protect the American people from a final stranglehold of regimentation. A voluntary pre-payment plan might provide a reasonable compromise."



President's Page



Doctors in this war are dramatizing the progress made by American Medicine during the last quarter of a century. From every theatre of operation and from every rank of the Army and Navy comes word of the outstanding work of the Medical Department. Thousands of lives have been saved that in former wars would have been lost, and the morale of the troops has been lifted by the knowledge that skillful help is always at hand.

Strangely enough, these doctors were not trained for war. The Army and Navy had nothing to do with their preparation. They were ready when hostilities broke out. Each of these men has spent from eight to twelve years of his life preparing himself to treat sick and injured civilians in a peace-time practice. He was doing the same high class work and was achieving the same marvelous results before he entered the Service, but it was less spectacular and was unnoticed by the public.

The doctor of today is the product of a long evolution of medical thought and teaching, based on the notion that a physician should have a broad cultural background and a thorough education in the art and science of medicine. Some of the steps in this evolution have been the standardization of medical colleges and hospitals, with the constant raising of these standards; the careful selection of the best qualified candidates for entrance to medical schools; the increase in pre-medical requirements and the lengthening of the courses of study necessary for a degree; the addition of from three to five years of post-graduate study, and the creation of the American boards of specialties.

This has been the training of our war doctors. When a student finished this training he was free to use his knowledge and his skill wherever it suited him best to go. Now that his country needs him, he is at the front and is making the medical history of this war a glorious one.

These men should not come home to find that their future has been blighted by state medicine. It is past belief that men so capable could have been as well trained by a government-owned, politically-managed medical profession.

The controversy over adequate medical care for all citizens is of the most vital importance to the doctors. It is their problem. They should formulate a plan that will meet the demands of society and that will leave the medical profession unshackled. Now is the time for some solid constructive thinking. If medicine is to retain its freedom, it must plan to meet the needs of present-day economic conditions, and it must lead the way.



"MEDSOC"

THE LETTER BANK OF THE INDIANA STATE MEDICAL ASSOCIATION

JOHN RAY NEWCOMB, M.D.

INDIANAPOLIS

Carl H. McCaskey, M.D., former president of the Indiana State Medical Association, sent questionnaires to the Indiana doctors in service a little over a year ago, to which one hundred twelve replies were received. I was asked to review these answers and to write an article for THE JOURNAL of the Indiana State Medical Association. At that time I was much impressed with the fact that a large number of the doctors asked for more letters, so I went before the Council of the Indianapolis Medical Society with the suggestion that it would be a very gracious thing if the Indianapolis Medical Society were to send one letter each month to each of the Indianapolis physicians in service. The Council looked upon this with favor and I, having "stuck my neck out," was asked to write the first letter. My first effort resulted in a very sad and lugubrious letter which I promptly destroyed, realizing that the men on active duty would rather smile than frown over serious subjects presented in these letters. Then I wrote a letter which I thought might give them a smile, and the response to this letter was most gratifying and made me feel that possibly the "MEDSOC" letters might prove to be of considerable morale value to the men in the service.

Hi, Medico!

We-all have been thinking of you-all much more than you realize and recently we have worried quite a bit in regard to your health. As you probably know, it is of utmost importance that you keep yourself in the best physical condition, and the following suggestions are made with the hope that they may be instrumental in helping you maintain a high state of efficiency:

1. **REST:** It is important that you have eight hours' sleep every night. Allow nothing to interfere with your

sleep. It is recommended that you take a nap each afternoon. Three-quarters of an hour to an hour should be enough.

2. **DIET:** Leading a sedentary life, it is essential that you watch your diet. Eat lightly. Leave the table when you are still hungry. Two meals a day are sufficient. Avoid heavy foods, such as potatoes, cabbage, red meats and bread. Substitute for them salads, broccoli, white meat of chicken or pheasant, veal cutlets,

asparagus and ices, with an occasional dish of chile con carne. The results will surprise you.

3. **EXERCISE:** Play golf, tennis, polo or badminton. Avoid taking long walks. If you do walk, take ten minutes' rest after each half hour of walking.

4. **MENTAL HABITS:** Avoid regimentation. Be an individualist and think for yourself. Allow no one to tell you what to do. Just use your own judgment.

5. **CLOTHING:** Let your individual taste determine what you are to wear. No hard and fixed rules can be given, but always brighten your appearance by wearing gay but not gaudy apparel. You will be surprised what a red necktie will do for you. Try it just once.

6. **RECREATION:** Every man in the service

should join The African Domino Corps and attempt to blitzkrieg his way to financial independence. If African dominoes prove too exhausting, try tiddlywinks.

Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

February, 1943

It was rather difficult to determine who I might ask to write the second letter. Finally, I thought of Mary E. Bośtwick, of the *Indianapolis Star*. As all of you know, she writes the "Last Page Lyrics" in the *Star*. I called her and told her what I wanted

★ THE "LETTER BANK" ★ INDIANA STATE MEDICAL ASSOCIATION

★ Each month a letter is sent by the Indiana State Medical Association to every physician on duty with the armed forces, hoping to bring to every officer a fuller realization of our great appreciation of the magnificent service he is rendering and the sacrifices made necessary by this service.

★ The Association takes this opportunity to express to the authors of these letters the sincere thanks of the medical profession of the State. The great appreciation of the . . . eleven hundred and eighty physicians who receive the letters each month makes all of the work associated with the "Letter Bank" seem indeed well worth while.

MEDSOC

her to do, and she enthusiastically agreed to write a "lyric" for the men in service. This letter was sent out in March of this year.

Hi Medico!

Whoa! Hold everything! I want you to meet Miss Mary E. Bostwick, of the Indianapolis Star. As you know, Mary is a veteran of the Baby World War. . . . Come here, Mary. Stand by me. Here is the Medico, so go ahead, Mary, and slip him the lyric. . . .

(Sufferers from certain types of illness must have written statements of registered physicians and surgeons before they can get additional food points for their ration allowance, says Marion County Rationing Administrator Taggart.)

Oh Doctor dear, O Doctor dear—remember prohibition
And what a burden it imposed on every kind physician?
When citizens were like to die and ever getting sicker
And nothing helped unless you wrote an order for some lickie?

Oh we've got rationing at home and Doctor—Holy Moses!
We wish that you were here to make some useful diagnosis!
How happy, Doctor, we would be if you could find some ailment
That might do something to improve the grocery curtailment.

There isn't any butter, Doc—we view the prospect bleakly—
So how about prescriptions for a quarter-pound bi-weekly?
If you were here perhaps you'd find that plenty of us have a
Strange affliction that requires two daily pots of Java.

Oh Doctor dear, we find that we have frequently an ache or two
That might be cured if you'd prescribe a juicy T-bone steak or two—
We wouldn't ask you to prescribe a potion or a pill—a
Quart of good ice cream would help—(and make it, please, vanilla.)

Oh Doctor, Doctor, things are fierce and we are pale and pindling—
Supplies of everything we like are shrinking, Doc, and dwindling—
Oh Doctor, Doctor, come back home and hand out some prescriptions—
We'll greet you with three hearty cheers and lady-like conniptions.

MARY E. BOSTWICK

Yeah, boys, things are getting fairly tight. Hoping you are the same,

Your 10-derly,

MEDSOC

March, 1943

Having met with success in asking Miss Bostwick to write a letter, I next called upon Governor Schricker, who promptly submitted the following:

Hi, Medico!

Governor Schricker of Indiana has a message for you this time.

Gentlemen—Governor Schricker:

A for America, the best land of all;
B for battle; you men heard the call.
C for commission of high rank and low;
D for devotion that makes your heart glow.
E for elation in doing your bit;
F for faithfulness—you've proven it!
G for gratitude which all of us feel;
H for honor—to you a great deal.
I for one who envies you all;
J for Japs whom you'll speedily maul.
K for kulture, a Hitleresque mask;
L for liking your particular task.
M for Medico—God bless your soul!
N for Nazi—a dubious foal.
O for oblivion and that's where they'll go;
P for perdition—the Lord wills it so!
Q for Quisling, a venomous tout;
R for revenge when you throw him out.
S for service—you're giving your best;
T for task; you'll be put to the test.
U for U-boats—just give them the gun;
V for victory, quickly won.
W for work that's setting the pace;
X for the unknown which all of you face.
Y for yellow and Hitler's shame.
Z for zero—that's all they will gain.

Bless you gentlemen. May God grant you a safe and speedy return.

Yours sincerely,

HENRY F. SCHRICKER

Well, boys, the Governor has gone from A to Z with you. He is covering a lot of territory. Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

April, 1943

Then I asked President Wells of Indiana University for a letter, and he submitted the following, which was sent out in May of this year:

Hi, Medico!

And here comes President Wells of Indiana University. . . . TEN-SHUN!

To Indiana Physicians in Military Service:

No greeting which I could send you would probably be more appreciated than the assurance that medical education as conducted by Indiana University is carrying on without impairment of standards.

The Indiana University School of Medicine is meeting the demands of the government and of the various medical associations despite the many difficulties growing out of the war. These difficulties include adjustments to the accelerated or year-round instructional program, military demands on the school's professional staff, unprecedented turnover in non-professional employees, and greatly increased cost of supplies.

An entering class of 128 began its professional training last January, and another class of the same size was chosen in March to enter medical school this September. Applications to each of these classes were carefully scrutinized by a committee of fifteen, composed largely of faculty members who also are practicing physicians. To the members of this committee, headed by Dr. Carl H. McCaskey, the University and, I believe, the medical profession generally is greatly indebted for long hours spent at a time when they are carrying a greatly increased load. Morale at the School of Medicine is high. The students are aware of the seriousness of the preparation they are making, and attendance at classes is at an unprecedented high average of 95 per cent.

The people of Indiana are proud of the services which its medical men with the armed forces are performing. The University is proud of its School of Medicine alumni now in uniform and appreciates hearing from them.

The University sends a special word of greeting to members of the staff of General Hospital No. 32, which was sponsored by the Medical Center and which left last month for Camp Bowie, Texas. We know that it will maintain the traditions of the hospital unit which went out from the Medical Center in World War I.

To you all, Indiana University sends best wishes and the pledge that it will endeavor with all of the forces and facilities at its command to maintain the high standards to which you in civilian life were committed and devoted.

And you can depend upon President Wells—he certainly is a straight shooter. Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

May, 1943

These first four letters were sent only to the physicians of Indianapolis who are in the service. Then Doctor McCaskey called me to ask if it would be possible to send these letters to all Indiana physicians in service, and immediately the Indiana State Medical Association assumed the task of sending monthly letters to all Indiana doctors in service.

With crossed fingers I next wrote Booth Tarkington, explaining the plan of sending letters to the doctors from Indiana, and very promptly I received a letter from Mr. Tarkington, with a personal note

to me which is typical of the attitude of everyone who has submitted a letter, that it is a privilege—not a favor. He said, "My dear Ray: I am glad, indeed, to write the enclosed letter to our doctors in the armed forces. Who would not welcome the privilege? I hope it will fit into a V-mail sheet. With good wishes, I am, Faithfully yours, Booth Tarkington."

This letter was mailed in June of this year.

Hi, Medico!

Booth Tarkington, one of the world's most revered and honored authors, has a message for you which should make you forget your trials and tribulations and make you a bit more proud of Indiana—and considerably more proud of yourselves. Gentlemen—Mr. Tarkington:

Of course we don't positively know, here at home, where you are. You may be in Iceland and you may be on the Equator; you might be as close to Indiana as San Francisco. So we are unable to think of you as in surroundings of any fixity, but this doesn't mean that we do not think of you. "The Folks Back Home" put in a great deal of time at that, in fact. I doubt if there's a minute in the day when the medical and surgical men with our forces aren't a part of our consciousness. We cannot think of the Army, the Navy, the Marines or the Coast Guard without thinking solicitously of you, "Out There," who go where they do and take care of them.

This thought brings us to the message I am here sending you on behalf of all of your stay-at-home fellow-Hoosiers. Our message is a paraphrase of the old familiar one quoted so often, so many years, by so many Indianians. Here we make it over to say "Good luck, Jim. Take keer o' yerself!" Don't forget the "self" part of it.

Your lifelong old admirer,

BOOTH TARKINGTON

And when Booth Tarkington says "your lifelong old admirer," he truly means it. Following a life-long friendship with Mr. Tarkington, it may well be said that he is, indeed, "The Gentleman from Indiana."

Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

June, 1943

For the July letter I asked Dr. Carleton McCulloch, the poet laureate of the Indiana State Medical Association, to contribute. His first effort was a serious masterpiece. At the bottom he wrote, "I don't like it; I will submit another one." And in a few days the following letter was received:

Hi, Medico!

This letter from Dr. Carleton B. McCulloch, a veteran of World War I, will show you what we stay-at-homes have to endure. Gentlemen, Doctor McCulloch:

Dear Medico:

At last our sufferings on the home front are appreciated by some of you lads who have nothing to contend with but bugs and bombs and chills and chow, and dengue and dysentery and fistulae and fractures and gangrene and gonococci. A medical officer who is 'way "down under," and vibrates, on moonlight nights, between his hospital and his dugout, which he shares with rats and snakes and crocodiles, writes me as follows:

"Taking it all in all, we are comparatively safe. Just think of all the dangers we miss—how we worry about those of you who are surrounded by ever-present potential dangers—slipping on ice, being struck by taxis, falling chandeliers, tripping over rugs, falling out windows, getting caught in revolving doors, falling elevators, tricky escalators, barked shins on brass rails, flying beer bottles, hargain basement crowds, foul balls out at Perry Stadium, catching cold while listening to dry sermons in damp churches, falling in the bath tub, stumbling over grand pianos—our hearts bleed for those of you who face such dangers without flinching."

O tempora! O mores! Aren't we the real heroes! !!

We now use ration coupons instead of money when we shuffle the pasteboards or roll the bones on Tuesday nights at the medical society meetings.

Yours for higger and better bunks in billets and barracks.

Enviously,

CARLETON B. McCULLOCH

The veteran medical officers of the baby World War have tried their darndest to escape the dangers enumerated above, but Uncle Sam wouldn't take us. We are awphuldamad.

Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

July, 1943

The next letter was written by Rabbi Morris M. Feuerlicht, Rabbi of the Indianapolis Hebrew congregation.

Hi, Medico! Gentlemen, Rabbi Morris M. Feuerlicht, of Indianapolis:

I deem it a gratifying privilege to join in raising a hand of "epistolary" salute to you. It really takes what the layman calls nerve—or will the censor permit a preacher to say "guts?"—for any of us these days to write any kind of admonitory or even spiritual message to his medicine-man serving on the battlefronts. Our only excuse or warrant for doing so is that you are fortunately still charitable and human enough to feel a normal sense of nostalgia for the rest of us. Frankly, however, your own nostalgia—whether professional or personal, or both—is hardly less acute or poignant than is ours for you. It is, of course, understandable that you should still feel a strong measure of concern for the home folks and patients you have left behind. You will therefore be interested to know that, apart from a little of what is known in the non-technical parlance of

your medical laboratories as "bellyaching" about taxes and rationing and such like, your erstwhile (and prospective) patients are on the whole doing right well. True, they have increased in numbers and in the variety of their several aches and ailments, imaginary and real; but this is in no sense to be accepted as the effect but rather as the immediate result of your having left them. And in all fairness it must be said that your elder colleagues are handling these with a finesse and success which the pressure of your absence at the front serves to exalt into still greater tribute to the characteristic and traditional altruism of your profession. You remember the old byword that by the time a man reaches the age of forty he is presumed to have become educated enough to be either a physician or a fool. Most of us at home, having already passed this physiologically critical borderline, will readily enough be classified into one or the other of these categories. Conversely, since most of you are already physicians who have not reached the Oslerian period, you have the assurance of still plenty of valid and legitimate material to work upon. Accordingly, may the day of your return be hastened by the complete and speedy victory of the cause to which you have already contributed so magnificently.

Sincerely yours,

MORRIS M. FEUERLICHT

Yes, we quite agree with the statement that "by the time a man reaches the age of forty he is presumed to have become educated enough to be either a physician or a fool."

Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

August, 1943

Mr. Wendell Willkie was the next person to whom I wrote asking for a letter, but I did not have much hope that he would reply. However, to my surprise and delight I received the following letter quite promptly:

Hi, Medico!

We have a real treat for you this month—a letter from Mr. Wendell L. Willkie. Gentlemen, Mr. Willkie:

It gives me sincere pleasure to have been asked to write one of the letters which are being sent to you members of the Indiana State Medical Association, now serving in the armed forces.

On my trip around the world I learned at first hand of the splendid work you doctors are doing in this war. Always the doctor has worked tirelessly and with unflagging courage, but in this war his efforts are more impressive than ever before, for with present-day medical knowledge and skill, the casualties are being kept at a minimum.

Our job here at home is to safeguard the future of this country, so that when this war is finally won you can come home to a world at peace, secure in the

knowledge that neither you nor your sons will again be called upon for the sacrifice you are now making. That is our job, and we will try to do it as well as you are doing yours.

The best of luck to you all.

WENDELL L. WILLKIE

In Mr. Willkie's recent book, "One World," he makes one statement which I think will interest all of you. "We must have a council of grand military strategy on which all nations that are bearing the brunt of the fighting are represented. Perhaps we might even learn something from the Chinese, who with so little have fought so well, so long. Or from the Russians who have recently seemed to know something about the art of war."

Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

September, 1943

Mr. Willkie's letter was mailed in September of this year, the month of the meeting of the Indiana State Medical Association. At the same time a letter from Doctor McCaskey was mailed to the medical officers from Indiana.

Hi, Medico! EXTRY! EXTRY! Indiana State Medical Association Special Edition! EXTRY! EXTRY!

Hello to All of You, Wherever You May Be:

You fellows in the Medical Corps are, in a way, like fleas,—you hop from place to place so fast we can hardly put our hands on you, but eventually we catch up with you—or maybe you catch up with us—but at least you have been located.

We all know how hard it was for you to leave home, and we are proud of you who have made the sacrifice. We feel that Indiana Medicine is doing a splendid war job, and when all the "shootin's" over, we feel confident that each of you will be most proud of the record made by Hoosier doctors in the armed forces.

On the train the other day, a lady in the diner was raising a lot of fuss about not getting enough butter, and a soldier who was sitting across from her offered her his pat of butter and said, "Do you think you could use my butter?" She shut up like a clam and he ate his own butter. After all, why should someone at home be fussy about anything? You fellows are not, and you are giving your all.

We are trying to keep medicine in Indiana the good old type of medicine where each patient has a right to choose his own physician. We want each of you to know that the Indiana State Medical Association is guarding to the best of its ability the fundamentals and standards of medicine, so that when you get back home after the war medical practice may be as nearly the same as you left it.

As you know, the state meeting will be held this month, and how I wish you could all be here. Well, you can't and that's that, but, by all that is holy, here's hoping this war will soon be over and that by 1944 we

can take each and everyone of you by the hand and say, "Howdy, boy, it's good to see you back"—and don't think we won't mean it!

With kindest personal regards, I remain,

Sincerely yours,

C. H. McCASKEY,
President, Indiana State
Medical Association.

When Carl says "Don't think we won't mean it," he ain't foolin' neither.

Hoping you are the same, I remain,

Your 10-derly,

MEDSOC

September, 1943

For the October letter we selected one from Indiana's beloved humorist, George Ade.

Hi, Medico! A letter in serious vein from one of the world's most beloved and famous humourists—George Ade:

One of the vivid recollections of my boyhood is that of hearing a small-town doctor, who had been a surgeon with the Union Army during the Civil War, tell of the conditions under which operations were performed at the front. The details were horrible beyond belief. Very often the surgeon did his amputating without the use of anaesthetics. As many volunteer helpers as could get a "hand-hold" on the wounded man held him down while the sawbones was performing his dreadful task. If he did not die of shock or loss of blood, the chances were that gangrene would get him later on. Sulfa powder, plasma and transfusions were still in the future tense. All of the antiseptic precautions which are the ABC of modern surgery were not available in a field hospital. Thousands of soldiers died of wounds which can now be treated with a reasonable certainty of complete recovery. I take off my hat to the Medicos who are with our boys in this world war. They will have at their command all of the formulae which were unknown to their great-grandfathers. They can snap their fingers at the Grim Reaper. They know the answers. They know the routines. They are the salt of the earth. More power to them!

GEORGE ADE

Barrie said, "The humourist's like a man firin' at a target—he doesna ken whether he hits or no till them at the target tells 'im." Before most of you men had made any definite plans about being born, George Ade wrote his famous "Fables in Slang." There are many "B" laughs in every one of them. He is still hitting the target.

Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

October, 1943

At the time this letter was sent, another was sent by Tom Hendricks, executive secretary of the Indi-

ana State Medical Association. If it were possible for me to blush I would certainly do so over this letter. My embarrassment reminds me of a verse of Lowell's:

"He stood a spell on one foot fust
Then stood a spell on 'tother.
But on which one he felt the wust,
He couldn't ha' told ye nuther."

Hi, Medico!

So you would like to know who "Medsoc" is?

Maybe that ought to remain a military secret until after the war, for certainly his quips and stories and wisecracks haven't been any help to the enemy.

In a way, "Medsoc" is the spirit of us all who were in the last war and who, because of old age or some other misfortune, just can't seem to get into uniform for this one—and are not at all happy over the situation.

As a matter of fact, "Medsoc" is a real live person whom I imagine most of you have come to like, expect to hear from regularly, and even to think of "10-derly," and who in turn wants you to know that no matter where you may be the gang back home hasn't forgotten you. If "Medsoc" hears a new story he passes it on to you. If he has a friend—"Tark," "Nick," George Ade, Cornelia Otis Skinner; Mary Bostwick—he or she is your friend too.

So, gentlemen, here's to "Medsoc," good story teller, good doctor, good friend, and a "good" guy—who has come out of retirement after, lo, these many years to serve on the War Participation Committee of the state association and whose principal job now is to get a line with a laugh through to you once in a while, and introduce you to the Hoosier greats and near greats. So, it gives me real pleasure to present to you the outstanding Medical Mystery of World War II—Colonel (inactive, and that burns him up) John Ray Newcomb, of Indianapolis—your own MEDSOC.

Best of luck, and God how we miss you!

TOM HENDRICKS

October, 1943

The following letter from Cornelia Otis Skinner was mailed last November.

Hi, Medico! With a feeling of elation and pride, I introduce to you Cornelia Otis Skinner, daughter of Otis Skinner, one of America's finest actors. Gentlemen, Cornelia Otis Skinner:

Dear Doctor Whoever and Wherever you are:

Of course, I couldn't be more pleased or flattered than I was when the Indiana State Medical Association asked me if I'd write you a letter. And at the same time I couldn't be in more of a quandary trying to think what in (I can't write the word, for the censor if he's a God-fearing man may delete it, but it begins with an H) a distant and totally unknown doctor would like me to write about.

Certainly not my symptoms, which aren't of interest even to myself. Nor can I send you a batch of Indiana news, for the only connection I've ever had with your

very nice state, other than acting there and having a lot of delightful Hoosier friends, is that of spending some weeks in an Indianapolis hospital having my tonsils removed. And that's more of a severance than a connection, isn't it? However, it's comforting to think that even if my roots go deep into the soil of Vermont, my tonsils have enriched the already fertile soil of Indiana! Which, I suppose can pass, conversationally speaking, for mutual ground.

On V-letters, there isn't much space. But I can and do send you my thoughts and my warmest good wishes, my dear, whoever you are, for a speedy victory for you and all of us.

CORNELIA OTIS SKINNER

Those of you who have seen Miss Skinner on the stage will agree that her illustrious father's talent has been handed down to his daughter. Miss Skinner is, in her particular line of endeavor, a truly great artist.

Hoping you are the same, I remain,

Your 10-derly,

MEDSOC

November, 1943

The December letter was written by Don Herold, and I am sure that the men who receive this letter will get a good laugh out of it.

Hi! Medico!

Christmas will soon be here and this letter from Don Herold will give you a good laugh. And here's Don Herold.

Dear Doctor—

You Indiana doctors in the service are probably awfully worried about us, your former patients, back home.

Personally, I never felt better in my life.

When I can't find a doctor to whom to tell my troubles, I just don't seem to have 'em. I just grin and bear what I ain't got.

It's going to take you quite a while to develop a lot of sick people when you get back into practice.

My rule, when you "docs" get back, is going to be "Never call a doctor until you have counted 120,000, and then, never except between the hours of 2:00 and 3:00 a.m." This will practically ruin me for you fellows as a patient, because I always get asthmatic after I have counted 60,000, and I am always too sleepy to sit up and get sick or die at 2:00 a.m.

Anyway, you men are doing a fine work right where you are, and we homefront hypochondriacs need a good dose of the neglect which you are now giving us.

Sincerely,

DON HEROLD

*How well we all remember the old Christmas poem—
"Twas the night before Christmas and all was a-souse
Not a creature was stirring not even a louse."*

Hoping you are the same, I remain,

Yours 10-derly

MEDSOC.

December, 1943

Unfortunately it is not possible to give you all of the letters received by "MEDSOC" from the men in the service. However, excerpts from a few of them will give you some idea of the wonderful reception given these letters. For example, "Dear Medsoc: Your recent V-mail letters have certainly added a few minutes of genuine pleasure out here on the other side of the world, where the grim realities of war exist." Another officer says, "The society's good-will letter of March first was received, and I can truthfully say it was the best morale builder I've encountered since joining up with Uncle Sam." A physician formerly in Aurora writes, "I do wish to take this opportunity to express my appreciation for 'MEDSOC'S' thoughtful and encouraging letters. I am sure many members of the state association now in the service enjoy that connecting link with their state affiliations." A lieutenant on a battlewagon in the South Pacific answered Carleton B. McCulloch's letter in verse. He says that it is not dangers they worry about, but another problem.

THE TROPICAL HEAT

I'm at a South Sea naval base
And doctor, what a hell of a place!
You can imagine the moonlight nights
When one can step out and enjoy the sights.
But what are the sights one usually sees?
A multitude of coconut trees.
These isles are shown in movies free,
And you sit back and look in glee.
But time spent here with soldiers in khaki
Is enough to drive the romantic wacky.
So what we need the very mostest
Is a right good-looking little hostess.
So get together, you old birds there,
And send us each a beautiful pair.
I'm not much of a writer you see
Hoping you're the same, Yours 10-der-lee.

One of the cleverest letters came from the South Pacific:

"Dear Medsoc: Your letter of Helpful-Tips-to-Better-Health arrived, and I have tried to follow all suggestions most carefully, with surprising results. Paragraph five 'Clothing' has been the most difficult for me. In complying with the suggestion of a red tie, I thought it would be very brightening and patriotic to wear it with my dress blues, which I did. You said that I would be surprised what a red necktie would do to me. You were quite right, for it resulted in a general court-martial, and now I am a seaman 2-c. I am afraid to wear it again because another demotion would find me in the Army. I am always glad to hear from home and do appreciate your helpful suggestions. Please let me hear from you again."

You have been given but a very few of the thoughts expressed in letters received from the men in service, but eventually I hope to have all of these letters in available form so that you can more fully realize the reward that has come from the "MEDSOC" letters.

In this article I have submitted only the letters sent out in 1943, and next year I hope to review the letters mailed in 1944.

Securing these letters, editing them and getting them ready to be mailed, seemed at first quite a task, but the responses received have made the "Letter Bank" a real pleasure.

In closing, may I paraphrase a little poem I read somewhere years ago?

*Go, little letters, go
Bearing an honored name!
'Til everywhere that you have went
They're glad that you have came.*

Hoping you are the same, I remain,

Yours 10-derly,

MEDSOC

IDENTIFICATION OF "MEDSOC" AUTHORS ON COVER PAGE

E. M. Shanklin, M.D.
Brigadier General Fred W. Rankin
Carl H. McCaskey, M.D.
Bishop Joseph E. Ritter
Thomas A. Hendricks
Governor Henry F. Schricker
Larue D. Carter, M.D.
John R. Newcomb, M.D. "Medsoc"
Dr. Jean S. Milner
President Herman B Wells
Rabbi Morris M. Feuerlicht
Meredith Nicholson

Booth Tarkington
George Ade
Don Herold
Major General Merritt W. Ireland
Cornelia Otis Skinner
Mary E. Bostwick
President Edward C. Elliott
Irvin S. Cobb
Eddie V. Rickenbacker
Ernie Pyle
Wendell L. Willkie
Carleton B. McCulloch, M.D.

SECRETARIES' CONFERENCE INDIANA STATE MEDICAL ASSOCIATION

Indianapolis Athletic Club

Indianapolis

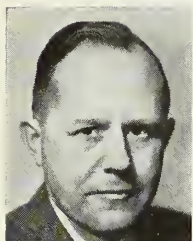
Sunday, January 23, 1944

Morning Session

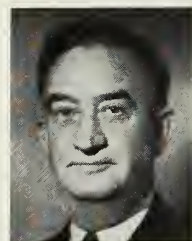
SCHOOL FOR SPEAKERS

(For those who will talk to lay groups
on Wagner-Murray-Dingell Bill)

- 10:30 a.m. Call to order by Floyd T. Romberger, M.D., Lafayette, Chairman of the Council.
- 10:35 a.m. "Outline Plan for Speakers," HOMER G. HAMER, M.D., Indianapolis, Chairman, Bureau of Publicity.
- 10:45 a.m. "The A B C's of Social Security," CLARENCE JACKSON, Indianapolis, Vice-president and General Manager, Indiana State Chamber of Commerce.
- 11:15 a.m. "Making the Speech Count," W. NORWOOD BRIGANCE, Ph.D., Crawfordsville, Professor of Speech, Wabash College.
- 11:45 a.m. "Addressing Local Lay Groups," F. S. CROCKETT, M.D., Lafayette.
- 12:10 p.m. Questions.



*W. Norwood Brigance,
Ph.D.*



Clarence A. Jackson

Afternoon

SECRETARIES' CONFERENCE

- 2:00 p.m. Call to order and opening remarks by A. M. MITCHELL, M.D., Terre Haute, Chairman.
- 2:10 p.m. Welcome to secretaries by N. K. FORSTER, M.D., Hammond, President-elect, Indiana State Medical Association.
- 2:20 p.m. "Hospital Plans in Indiana," CHARLES N. COMBS, M.D., Terre Haute.
- 2:40 p.m. Discussion by L. FERNALD FOSTER, M.D., Bay City, Michigan, Secretary, and WILLIAM J. BURNS, Executive-Secretary, Michigan State Medical Society, Lansing, Michigan, where Blue Cross and medical service plans are operating.
- 3:00 p.m. "Public Relations and the Medical Profession," EDWARD J. McCORMICK, M.D., Toledo, Ohio, Past President, Ohio State Medical Association, and member of the Council on Medical Service and Public Relations of the American Medical Association.
- 3:30 p.m. Questions and answers.
- 3:50 p.m. "National Legislative Problems," J. W. HOLLOWAY, Jr., Chicago, Secretary, Bureau of Legal Medicine and Legislation of the American Medical Association.
- 4:20 p.m. "Local Legislative Problems," NORMAN M. BEATTY, M.D., and J. WILLIAM WRIGHT, M.D., Indianapolis, Co-chairmen, Committee on Public Policy and Legislation.
- 4:40 p.m. "Your Part in Making a Better State Medical Journal," E. M. SHANKLIN, M.D., Hammond, Editor of THE JOURNAL.
- 4:50 p.m. Questions and answers.



William J. Burns



*L. Fernald Foster,
M.D.*



J. W. Holloway, Jr.



*Edward J. McCormick,
M.D.*

Evening

- 6:15 p.m. Dinner—Indianapolis Athletic Club.
- Speakers: (1) J. T. OLIPHANT, M.D., Farmersburg, President, Indiana State Medical Association.
- (2) Nationally known speaker, to be announced later.

REQUIREMENTS UNDER THE PROVISIONS OF THE PRENATAL LAW

GEORGE W. BOWMAN, M.D.*

INDIANAPOLIS

Three years ago, January 1, 1940, our Indiana Prenatal Law became effective. In retrospect, and considered grossly, it appears that it has been fairly satisfactory. However, many physicians are not drawing blood specimens routinely on all expectant mothers, or either are not reporting it or are not noting the fact, the time taken, and the laboratory result on the revised birth certificates as required by the law.

In defense of our professional colleagues, it must be said that many pregnant women do not apply for medical care until labor is imminent or already started. The health officer in one section of Indiana made a survey to ascertain when blood tests were being taken by physicians. This covered 164 births, and it was found that 21.3 per cent had bloods during the first trimester, 20.7 per cent during the second, 25.8 per cent during the third, 12.9 per cent at delivery, 19.3 per cent had no bloods taken, and in 1.82 per cent no information was available. Only 28.4 per cent had had the advantage of a blood test by the end of the fourth, and 35.5 per cent by the end of the fifth month. These figures indicate by this spot survey that two-thirds of our expectant mothers will not have had their syphilis diagnosed early enough to allow sufficient treatment by standard routine methods to prevent the disease in their offspring if they are infected.

As proof of improved cooperation and growing familiarity with the prenatal law, we cite the fact that there has been an increasingly larger number of prenatal blood specimens examined in the central State Board of Health and private, approved laboratories in the successive years since the law has been in effect. It may be assumed that many of the doubtful laboratory reports were in individuals who had had or already were under treatment. Conversely, the percentage of positive serologic reports has decreased, namely, 1.64 per cent, 1.57 per cent, 1.45 per cent in the respective years 1940, 1941, and 1942. For the same three years the number of births has increased, namely, 62,045, 65,681, and 74,134. An increase in case finding of serologic syphilis has been seen with a routine test of selective service, premarital and prenatal examinations. The usual flood of wartime marriages and war babies has run true to form. While an assumed 16,000 and 13,000 more marriages during our two war years have disclosed an increased number of positive bloods and an increased positive serological rate, there has been a steady decline in the positive prenatal serologic rate.

The morbidity and mortality rates of congenital syphilis are in direct proportion to the incidence of acquired syphilis in the general population. Prevention and treatment of acquired syphilis quickly affects the prevalence of congenital syphilis. It has been contended that "without maternal syphilis there can be no syphilis in the offspring." The belief that it is a genuinely intra-uterine infection transmitted through the placenta from mother to child is the basis for our present method of prevention. Expectant mothers tolerate treatment well, but extra caution and closer observation must be exercised because of the additional load and the possibility of associated toxemia of pregnancy. Every additional treatment further minimizes the risk of syphilis in pregnancy. The greatest dependence is placed in the use of arsenical drugs with compounds of bismuth as the alternate drug of choice. Until a short time ago the massive arsenotherapy or five-day drip treatment, although not at first combined with heavy metal, has substantiated this. It bids fair to offer the highest hope and favorable prognosis for babies of syphilitic mothers in active stages of their infection. Results are best when treatment is given early, but treatment in any stage is indicated and useful.

The diagnosis of a baby born with clinical syphilis is not difficult, but the status of an apparently normal baby born to a known syphilitic mother requires care, skill, patience and time to prove. Diagnosis should only be made on positive findings, and even with characteristic clinical symptoms should be corroborated by positive laboratory findings. Treatment which will of necessity be of long duration should not be instituted until the diagnosis is established.

Earlier prenatal care and an expanded educational program to expectant mothers to seek this when they first suspect their pregnancy, and the insistence on examination, including a blood test, is necessary. Facilities for treatment already exist. Laboratory tests are available to all. Free antisyphilitic drugs may be had on requisition by any licensed physician for his needy or deserving patient. Subsidized clinics and local health departments will cooperate in diagnosis or treatment. There is no excuse for any expectant mother known or suspected of having syphilis to be without these services in our state. Here then is the challenge "Healthy babies for Indiana." This will be possible only when the profession, health agencies, and the public cooperate.

An earnest appeal is made here to our physicians to report all cases, especially of expectant mothers,

* Director, Division of Venereal Disease Control, Indiana State Board of Health.

with positive blood tests and for the adequate treatment of these mothers to insure a healthy posterity. The offer of any needed and desired assistance in follow-up, in investigation and in arrange-

ment for treatment at most convenient points, and of free drugs to any physician having such deserving patients, is again repeated. Our goal is the eradication of prenatal syphilis.

WAR MANPOWER COMMISSION INAUGURATES PROCUREMENT AND ASSIGNMENT OF NURSES

ETHEL R. JACOBS, R.N.

Chairman, Procurement and Assignment Committee of State Nursing Council for War Service

Indianapolis

Physicians long have been familiar with the words "Procurement and Assignment," but something new has been added to the now familiar combination of words. The Procurement and Assignment Service for physicians, dentists, veterinarians, and engineers now has another classification, "nurses." Since America entered the war approximately 40,000 nurses have volunteered their services, but the quota set by the Army and Navy has not been met. In this state 589 nurses entered the military forces this past year, which was beyond the quota given Indiana. This patriotic zeal should continue because many more will be needed next year.

But no one knows as well as the physician that nurses are needed at home, too, so the War Manpower Commission is going to see that not only the armed forces are supplied but that the civilian population is taken care of. The first step to bring about this accomplishment is a classification of all nurses, whether or not they are eligible for military service, and a job analysis to determine their essentiality.

Nurses found to be eligible for military service and filling a non-essential position will be declared available to the Red Cross Recruitment Committee. Those in positions considered non-essential will be urged to take essential posts so that no nursing skill will be wasted.

Since it is well known that nurses have high regard for the opinion of physicians, it is hoped that Indiana physicians may be a great factor, psychologically at least, in affecting this transference of nurses from non-essential to essential jobs.

Working through local Procurement and Assignment committees, all nurses in Indiana will be classified into five groups. These include:

Class 1. Available for military service, not holding an essential position, and potentially qualified for military service. They must be under forty-five and may be unmarried, or, if married, have no children under fourteen years of age.

Class 2. Available for relocation outside or within the community.

Class 3. Essential for limited duration or until a replacement can be secured.

Class 4. Essential for unlimited duration.

Class 5. Not available for either military or emergency civilian service because of physical disability, age, or other reasons.

It is the intention of the Procurement and Assignment Service to impress nurses with the fact that it may be just as patriotic to stay in a job at home as to leave for military service. In some instances where large numbers already have left a community or an institution for the Army or Navy, those who remain are performing an invaluable service, and they should be recognized by a classification of "essential."

Physicians will be interested to know, too, that only 5 per cent of the nurses in executive and teaching positions (women with postgraduate training) will be required by the military, so some of the nurses in the most responsible positions can be expected to continue in their jobs. The Army and Navy needs young nurses who have just completed their training. With this in mind, physicians should take every opportunity to guide young women with personal qualifications for the profession into the Cadet Nurse Corps.

All employers of nurses, such as patients, physicians, and institutions should be informed of the present status of the nursing profession if their cooperation is to be gained in releasing nurses for essential positions. They should know that many communities are almost completely destitute of nursing power.

The members of national and state nursing committees feel that nurses should be considered as rationed commodities, and their services used as such. Physicians are urged to use group nursing as one means of caring for their patients, and to use private nurses only for critical cases. They should arrange to replace office nurses who are eligible for military service.

CRITERIA

Definite criteria of essentiality for the various types of nursing services have been set up by the War Manpower Commission.

Hospital Nursing Personnel

In hospitals which do not have schools of nursing, nurses who are essential in positions such as director, assistant directors, supervisors, head

nurses, and staff nurses are classified as essential, and where eligible for military service are to be classified as essential until they can be replaced.

Personnel practices of the hospital which affect nursing efficiency—reasonable working hours, good living conditions, adequate salaries—are to be considered. Other points to be given consideration are the necessity of adequate nursing supervision of non-professional workers in order to safeguard the welfare of the patient; limiting the activities of nurses to duties requiring professional skill; and insuring minimum adequate nursing care to all patients in all hospitals in the community.

Private Duty Nurses

Nurses engaged in private-duty nursing who are eligible for military service should be classified as available. Those not eligible should be used first for the care of acutely ill; in hospitals through group nursing, or for the care of one patient where group nursing cannot provide sufficient care; and in homes only when it is impossible to provide enough care through facilities such as visiting nurse associations and hourly nursing services. They may also be used for meeting other civilian needs as general staff nurses in hospitals; in public health nursing duties not requiring special preparation or experience; as staff nurses in industry under adequate supervision; and as nurses in physicians' offices where nursing service is required.

Office Nurses

Nurses engaged in office nursing who are eligible for military service are to be classified as available for such.

Physicians' offices not needing professional nursing service are to be requested to release their nurses for use in other types of essential nursing service and employ non-nursing personnel, although it is conceded that the practice of physicians remaining in civilian service has in many instances increased to such an extent that there is a greater need for efficient office nurses. It is recommended that nurses should be used for office nursing who are not eligible for military service and are not qualified in fields of nursing requiring special preparation, such as teaching or public health nursing. Also, a reasonable length of time is to be allowed for preparing nurses to replace those who are performing highly skilled nursing duties in physicians' offices.

Other Criteria

Schools of Nursing must retain a staff of instructors, supervisors, and staff nurses to provide adequate educational opportunities for the large group of students now being recruited, for if this production program is jeopardized all branches of nursing service will suffer for many years.

Public Health Nurses eligible for military service, who are essential, are to be so classified until they can be replaced. However, when they are listed as available for military service, preference is to be given to those who have not had special preparation for public health nursing. They are to carry out a generalized service in a ratio of one nurse to five thousand population, and are to be relocated where necessary.

Nurses in Industry, if eligible for military service, are essential only until they can be replaced. They should limit their duties to professional nursing duties and use non-professional technical aides.

These are the criteria which have been established. After local and state Procurement and Assignment committees have determined which positions and which nurses are essential, nurses are to be notified of their status. They may change positions if their present work is considered non-essential. Then the Red Cross Nurse Recruitment Committee will receive clearance forms on all nurses remaining in non-essential positions and those who are eligible for military service will be invited to apply. Those not eligible will be advised of essential positions they might fill. An effort will be made to have every nurse serve in the position where she is most needed and where her abilities may be used to the fullest extent.

Physicians need nurses; they must have their services. But today, when there are great demands to meet military needs, physicians, too, must recognize the need for some regulation, some curtailment in this supplementary service, for nurses have an essential job, too. If the physicians will cooperate in this plan of sorting out those eligible and non-eligible for military service, those in essential and non-essential jobs, they will be aiding the military service and will be insuring their patients the care they cannot always be afforded when nursing service is unregulated. There are not enough nurses to allow service as usual.

Pay your dues in January
and avoid delinquency

PROCUREMENT AND ASSIGNMENT

(The following pertinent question-and-answer list is from the War Manpower Commission, Procurement and Assignment Service, Washington, D.C.)

QUESTIONS AND ANSWERS

- Q. What are the present age limits for service in the Medical Corps of the Armed Forces?
- A. The upper limit in the Army is, in general, the forty-fifth birthday, but for specific position vacancies men up to 60 are eligible. The limit in the Navy is, in general, the fiftieth birthday.
- Q. What is the present status of physical requirements?
- A. The Navy at the present time still has the highest standards, although they are lower than they were. The Army is next, and those who are physically disqualified for Army service may be eligible for commission in the United States Public Health Service.
- Q. What ranks are being offered by the services at the present time?
- A. The Army is limiting those under 38 to first lieutenantcies and those about 38 and over to captaincies and above if they meet special requirements of the Surgeon General. The latter rank depends upon special qualifications. The Navy is limiting those 34 and under to lieutenantcies, jr. gr., those from 34 to 38 lieutenantcies, sr. gr., and those from 38 to 44 lieutenant commanderships. For specific position vacancies requiring special qualifications higher commissions may be offered. The Public Health Service has commissioned ranks similar to those in the Army.
- Q. What are the present needs of the services?
- A. All three branches of the Armed Forces are in immediate dire need of several thousand additional medical personnel. This immediate period of need is between now and January 1.
- Q. Why is the Public Health Service classed as one of the branches of the Armed Forces as far as medical officers are concerned?
- A. For many reasons, among them the fact that they supply the medical personnel for the U. S. Coast Guard. Physically qualified eligible officers are assigned by the Public Health Service for active duty with the Coast Guard and may be assigned anywhere the American flag flies.
- Q. Why have so many practitioners who are capable of serving long hours in civilian practice been disqualified for military service?
- A. The exigencies of service in combat areas are such that civilian practice is no criterion of physical qualification. The services at the present time have a full quota of those that they can accept for limited duty. They are being forced to discharge some at present. Certain individual physicians who still will be able to undertake heavy civilian duties are no longer able to cope with the needs of combat troops.
- Q. Why is it necessary for a physician to take an indoctrination course after entering the Medical Corps?
- A. The reason for this is that a physician becomes a medical officer, which means that he is at all times an officer subject to the duties of other officers of other branches of the service. He must be responsible for those under his command and must be entirely capable of meeting any situation which confronts such personnel as is under his direct supervision, whether it be in open field duty requiring the setting up of field hospitals or the maintenance of food supply and shelter for his personnel, as well as a correlation of the activities of his group with the other services under the same command.
- Q. Is it true that the Armed Forces are not making efficient use of their medical personnel?
- A. There have been many occasions in the past when appearances would lead anyone to believe that they were not. At the present time efficient use is being made of such personnel, and it must always be remembered in this connection that a reserve supply of such personnel must be maintained for immediate assignment to duty. Such a group must have been trained together to meet the situations it will face immediately after assignment and can not be gathered together at the last minute to be assigned to some specific post. Furthermore, the planning of any military campaign requires a complete lineup of all services. If reverses are suffered, such men who are held in preparation of projected positions may not be able to fill such positions and must be held for further plans. War, by its very nature, is not essentially efficient, but the lack of medical personnel in the various branches of the Armed Forces has resulted in a high increase in their efficient use.
- Q. On the basis of present ratios of physicians to individuals, which service has the greatest need at the present time?
- A. The Army ratio is slightly over 5 per 1,000, whereas the Navy is somewhat under 4 per 1,000. Therefore, the Navy needs men somewhat more than the Army.
- Q. Why is any man under 38 ever classified as essential?
- A. He is only essential if he were to leave his community or his institution and there were no replacement for him. No man under 38 is,

- as a general rule, considered permanently essential, but only essential until he can be replaced by another physician who is not eligible for service with the Armed Forces.
- Q. Has not the civilian population been endangered by the number of physicians who have entered the Armed Forces?
- A. Not for the nation at large. There are various problems of redistribution which have been partially or completely solved and some which will be difficult to solve, but if such distribution is equitable there is no shortage at present for minimal adequate civilian care.
- Q. Will not the needs of the services continue and require that additional personnel leave civilian life?
- A. To some extent, yes, but primarily the services will be able to meet their own needs for replacement from the students they are training at present. The Navy may need some additional personnel even though they are also training students. The Public Health Service will continue to have needs since they do not have any students in training.
- Q. Why do not the Armed Forces adopt the liberalization of qualifications that exist in England and elsewhere?
- A. Because it is essential that American standards be maintained for the men in the Armed Forces as well as on the home front. Comparisons with the Armed Forces of other nations are not in order any more than comparisons of physician-population ratios on the home front are with those of other nations. The mortality in the Armed Forces at the present time is astoundingly low and every effort will be made to keep them at that level. This will obviously require further sacrifices on the part of those on the home front, but the Procurement and Assignment Service is constantly aware of the fact that supplies of all kinds must continue to flow to those who are on active duty, and that therefore the health of the home front is as much a part of the war effort as is the health of the soldier.
- Q. What action does Selective Service take on physicians?
- A. Although local boards differ somewhat in their actions, in general, no action is taken at present on physicians or others over 38. Reclassification of those under 38 is going on constantly and dependency is not considered to the same extent as it was in the past.

NECESSITY OF MAINTAINING EMERGENCY MEDICAL UNITS

December 1, 1943.

To the Chiefs of Emergency Medical Service,
Region V.

My Dear Doctor:

To those of you who have served faithfully for the past two years, I am directing this letter of appreciation, thanks, and affection, as well as an appeal for continued cooperation.

It must seem evident to you, as to all observing and thinking people, that our war progress, and the lack of air raids to date, have tended to distract public attention from some very significant values of Civilian Defense. In recognition of this fact, I am asking for your continued cooperation on the following basis:

Those of you who have had letters from me, or who have heard me address your state medical association meeting, or the College of Surgeons meeting, know that for the past two years I have appealed to you to coordinate and integrate the organization of your Medical Division or Office of Civilian Defense into the needs of your city or county departments of government. It is not only far-sighted and good organization, but it is basically and fundamentally sound, because few of our communities have had well-organized disaster squads for Emergency Medical care (most of them are on paper only) that can serve communities in disasters caused by natural causes and carelessness, as well as by enemy action and sabotage.

In this Fifth Region we have always emphasized the long-view or long-range plan. At this time, in the interest of our greatest usefulness, it is well for us to re-emphasize this long-view idea.

Our Chief Medical Officer and his associates in Washington have forecast our needs splendidly, and as a result many of you have received valuable literature and equipment that have served your program well. Hence, nothing in this letter to you should alter, take precedence over, or take the place of publications or directives that have been issued from our national office.

With a changing public attitude, there are two things you should do, not only to anticipate, but also to circumvent disintegration of your effective medical organization:

1. Continue to advise the civilian population and the personnel of your Emergency Medical Service that the war is not yet won, that there is nothing sure and nothing final until the enemy capitulates. Remind them also of the many wartime disasters throughout the country in which the Emergency Medical Service has been responsible for the saving of many lives. Keep the Emergency Medical Service intact.
2. If you have not already done so, coordinate and integrate your Emergency Medical Service of the OCD into well-established community, city or county departments of government.

All well-ordered and well-organized communities of moderate size have departments of public health, public welfare or public safety. The programs of health, welfare and safety predicate and imply Emergency Medical Service, yet our communities have never had this safeguard and this service adequately developed.

It is unlikely that many communities would consider organizing a separate department of government for this service, but most communities would see the value of creating a Division of Emergency Medical Service in one of the already established departments.

Hence, let us hold on to our Emergency Medical Service, to function as such for the duration. Let us pave the way for our organization to be fully assimilated and integrated after the war into one of those departments, that communities may profit by the training you have received and the efficiency you have maintained and perfected.

We must be ready to handle disasters from natural and accidental causes in time of peace, just as we have been prepared to handle disasters from enemy action and sabotage in time of war. Other agencies may be prepared to give food, shelter and clothing, but to the medical profession must be committed medical care, especially in the event of a major catastrophe.

The world is going to be a long time getting straightened out. The medical profession must not lose a single opportunity to do its bit toward making the process shorter and safer.

Continue to consult me regarding any of your problems.

Faithfully yours,

WILLIAM S. KELLER, M.D.,
Senior Surgeon (R) USPHS,
Regional Medical Officer.

UNDER THE CAPITOL DOME

BOARD URGES SEWER CONSTRUCTION

The construction of sewers and sewage disposal plants in Hoosier cities and towns as post-war projects is being urged by the Indiana State Board of Health.

Dr. Thurman B. Rice, acting secretary, points out that this type of construction would serve a double purpose: first, it would constitute a valuable and seriously needed contribution to public health; and second, it would provide immediate employment for returning members of the armed forces and for persons thrown out of work by the cessation of war production.

Plans for the post-war period will be discussed at a two-day conference in Indianapolis on January 12 and 13. Groups interested in elimination of stream pollution, and representatives of industrial groups which have been contributing to the pollution of Indiana waterways, will attend. Among the groups will be the Izaak Walton League, the Indiana Farm Bureau, Incorporated, manufacturers, canners, and operators of straw board plants.

The state health department already has started its program to interest the officials of cities and towns in post-war sewer and sewage disposal plant construction. Copies of resolutions on the subject are being sent to these officials and also to officials of manufacturing plants. These serve to call attention to the need of the construction.

All phases of the plan, including the health aspects and the post-war employment angle, will be discussed at the January meeting.

Dr. Rice said that the proposed sewer construction is especially important from a post-war em-

ployment angle because this work can be started almost immediately, once the plans are ready. That, he explained, is why his department is urging the city and town officials and others affected to get their plans ready now. The work can be started without delay, once the need for employment develops.

The principal ingredients which go into sewer construction are gravel, concrete—and labor. Reinforcing steel also is needed, but Dr. Rice said that it will be a simple matter for the steel companies to convert their plants so that they can turn out this product, and some plants are turning out this type steel in connection with the war effort.

Almost every city and town in the state needs new sewers or need replacements and extensions, Dr. Rice said, so that the project will be state-wide in its scope. The cost, on a state-wide basis, will run into tens of millions of dollars, and a very large proportion will go for labor.

STATE MEDICAL BOARD ACTION

The Indiana State Board of Medical Registration and Examination revoked the licenses of two physicians and restored one license that had been revoked earlier. Those whose licenses were revoked were Dr. George E. Ellerbrook, of Vevay, and Dr. Benno M. Gundelfinger, of Indianapolis. The license of Dr. Robert B. McAlpin, of Greenwood, was restored. The action was taken at a meeting in Indianapolis on November 16. The next annual meeting will be January 11, 1944, in Indianapolis.

Certificates have been issued to applicants who successfully passed the examinations conducted by the Indiana State Board of Medical Registration and Examination September 14, 15 and 16, in Indianapolis. A total of 120 applicants passed medical examinations. The highest grade was made by James C. Fish, a graduate of the Indiana University School of Medicine.

Approximately 65 per cent of the young doctors will enter the medical branches of the Army and Navy, while the remainder will remain here to help relieve the shortage of doctors on the home front.

Indiana University graduates who will receive licenses are:

Anthony, Walter P.
Bartley, Max D.
Beluk, Stephan R.
Boerger, Victor L.
Boyd, Clarence E.
Brennan, James E.
Brown, Leland G.
Brown, Stewart D.
Buckles, David L.
Butler, John O.
Campbell, Sam W.
Carter, Eunice R.
Chattin, Robert E.
Christman, Robert A.
Courtney, John W.
Dagley, Hubert R.
DeFries, John J.
DeLawter, Hilbert H.
Dickerson, Betty J.
Donnelly, Everett F.
Dukes, Joseph E.
Egnatz, Nicholas, Jr.
Ernst, Clifford E., Jr.
Ettl, Edward J.
Ferguson, Morris R.
Fish, James C.
Fisher, Gerald E.
Ford, William B.
Franklin, Wm. L.
Freed, John E., Jr.
Funk, John W.
Garrett, Robert A.
Gibson, Ralph L.
Glosson, Jack R.
Gripe, Richard P.
Harding, Myron R.
Hatfield, Jack J.
Hennessee, Philip C.
Herrold, Don W.
Hetherington, John A.
Hill, Kenneth A.
Hinchman, Jean F.
Hodurski, Zigfield
Huckleberry, Carl D.
Hughes, Richard R.
Humphrey, Paul E.
Huse, William M., Jr.
Jarrett, Paul E.
Joest, Charles O.
Johnson, Jerome M.
Johnson, Robert E.
Jones, Robert F.
Kammen, Robert
Keck, Carleton A.
Kimmich, Robert A.
Kintner, Elgin P.
Klaus, Julius M.

Kosanke, Harold E.
LaFollette, Robert E.
Lambert, C. W.
Leff, Abe
Lingeman, Roger E.
Logan, Richard S.
Lohman, Robert M.
McClellan, John B.
Makovsky, Theodore
Martin, Joe M.
Masters, John B.
Mellen, John R.
Meschuk, John D.
Miller, Jack B.
Mitchell, Robert H.
Modisett, Marcella S.
Morris, Robert A.
Morrison, Lewis E., II
Ornelas, Joseph P.
Painter, Donald S.
Palmer, Russell H.
Peterson, Lowell F.
Plank, Charles R.
Raines, Dale S.
Randall, Don Q.
Rogers, Evered E.
Rosenthal, Ira M.
Ross, Evelyn G.
Rowe, Howard H.
Rudicel, Max W.
Rudolph, Stephan J., Jr.
Rush, Clyde E.
Salzman, Maurice
Scamahorn, Malcolm O.
Schafer, William C.
Schmidt, Robert L.
Sheridan, Joseph L.
Shevchik, Alexander
Stayton, Chester A.
Steele, Paul W.
Stephens, Donald E.
Tempey, Fred W., Jr.
Unger, Loring L.
Van Fleet, Josephine
Verplank, Dean T.
Walker, Floyd B.
Weber, George R.
Weiner, David
Westfall, Beverly K.
Wigent, Ralph D.
Williams, Hugh L.
Wisch, Albert J.
Wooling, Kenneth R.
Wright, Robert Wm.
York, Frank A.
Zink, Robert O.

Those from out of state schools who will receive licenses are:

Chen, Ko Kuei, Johns-Hopkins University School of Medicine
Galante, Vincent, Loyola University School of Medicine
Mendez, Carlos, Northwestern University School of Medicine
Korn, Bernard J., University of Illinois School of Medicine
Hoachlander, Eldon G., Temple University School of Medicine
Wyatt, James L., III, Loyola University School of Medicine

Deaths

Charles E. Triplett, M.D., of Moroco, died November twenty-fifth at the age of eighty-one. He was a graduate of the Rush Medical College, Illinois, in 1895.

* * *

Arthur M. Sullivan, M.D., former Attica physician, died in South Bend on November twenty-seventh, at the age of sixty-two. He was a graduate of the Indiana University School of Medicine in 1909, and specialized in surgery. Doctor Sullivan was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Donn P. Murray, M.D., of Dunkirk, died at a hospital in Muncie on November ninth. He was seventy-three years of age. He was a graduate of the Medical College of Indiana, Indianapolis, in 1894. Doctor Murray was a member of the Jay County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

James H. McNeill, M.D., former Paragon physician, died at New Castle on November fifteenth, aged sixty-three. He was the attending physician at the Indiana Village of Epileptics. Doctor McNeill graduated from the University of Nashville Medical Department, Tennessee, in 1906. He was a member of the Henry County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

William F. Clevenger, M.D., of Indianapolis, died November twentieth at the age of sixty-nine. He graduated from the Medical College of Indiana, Indianapolis, in 1894. Doctor Clevenger had practiced in Indianapolis since 1898, and had limited his practice to Otology, Laryngology and Rhinology. He was a member of the Marion County Medical Society and the Indiana State Medical Association, and he was a Fellow of the American Medical Association. He also was a member of the American Academy of Ophthalmology and Oto-Laryngology and the American College of Surgeons.

Military News

Captain Ernest R. Beaver, of Indianapolis, is now stationed "somewhere in England."

Lieutenant Charles P. Anderson, of Gary, has been promoted to a captain in the Army Medical Corps. He has been stationed in England.

Word has been received of the change of address of Lieutenant Crawford N. Baganz, of Uniondale, from Camp Peary, Williamsburg, Virginia, to a Fleet Post Office address, San Francisco, California.

Lieutenant Robert A. Craig, of Indianapolis, has completed training at the Medical Field Service School, Carlisle Barracks, Pennsylvania, and is on his way to service with Army troops in the field.

Captain Richard E. Estlick, of Fort Wayne, has recently been home on leave of absence from his station in Labrador.

Melvin Durkee, son of Mr. and Mrs. G. W. Durkee, of Evansville, has recently been promoted to the rank of lieutenant colonel in the Army of the United States. He is chief of the Surgical Service, Station Hospital, Fort Knox, Kentucky. Lieutenant Colonel Durkee held a reserve commission, and was called to active duty with the rank of first lieutenant in October, 1940.

Lieutenant Colonel J. W. Bowers, of Fort Wayne, post surgeon at a station hospital at Daytona Beach, Florida, writes that they are having wonderful weather—flowers are in bloom; oranges, grapefruit and tangerines will soon be ripe. Recently they picked two bunches of ripe bananas off their banana tree and served them in the mess hall. He says that they are very proud of their hospital installation there, as it is one of the finest that one could desire.

Lieutenant-Commander W. D. C. Day, of Seymour, has been promoted to the rank of full commander in the United States Navy, the promotion designated as being retroactive to the time he was on active duty in the South Pacific—August, 1942. Commander Day, now post surgeon at Camp Pendleton, Oceanside, California, the largest Marine Corps camp in the United States, entered the service several months before Pearl Harbor. He served with the marines in their earlier landings on islands in the South Pacific.

A captaincy has been given to Dr. J. C. Glackman, of Rockport, who is now serving with the Medical Corps in North Africa.

Nihil Kemper Venis, M.D., of Muncie, now stationed with the Army Medical Corps in Sicily, has been promoted to a captain.

E. A. King, M.D., of Evansville, has been commissioned a lieutenant, senior grade, with the United States Coast Guard, and is on active duty at Seattle, Washington.

Samuel J. Klor, M.D., of Indianapolis, has been promoted to a major in the Medical Corps. Major Klor is on a hospital ship and has recently returned from his eighth trip asea, transporting injured soldiers from the war zone. He enlisted in the summer of 1941.

The Delaware-Blackford County Medical Newsletter of November 20, 1943, reports that they had a letter from Dr. G. W. Gustafson, of Indianapolis, who is now stationed at Geneva, Nebraska. Dr. Gustafson has just returned from New Guinea, and in his travels in the South Pacific he met Lieutenant J. T. Oswalt, of Dunkirk, and Lieutenant Colonel John Lansford, of Redkey, and reported that they are in good condition.

Officer changes on the staff of the station hospital at Fort Benjamin Harrison include Captain Mallory P. Weems, of Jeffersonville, chief of the eye, ear, nose and throat clinic. Captain Weems has been transferred to the induction station at Louisville, Kentucky. He has been on active duty since July of last year, and served at the Indianapolis induction station prior to his assignment at Fort Harrison.

Major Harold J. Halleck, of Winamac, a veteran in military circles, beginning with eighteen years of service with the Indiana National Guard, has been advanced to the rank of Lieutenant Colonel. Simultaneously with his promotion, Lieutenant Colonel Halleck was assigned as Division Surgeon of the 80th Division, to which he has been attached for some time. The division recently was transferred from Camp Phillips, Kansas, to a base in southern Arizona, where the troops are on desert maneuvers. Lieutenant Colonel Halleck entered the Federal service in the spring of 1942 with the rank of major, a rank which he attained during his National Guard days with local units which were federalized in January, 1941.

The address of Captain John P. Marsh, of Blountsville, is now an A.P.O. address, No. 12655, c/o Postmaster, New York, New York.

Captain James M. McFadden, of Fort Wayne, who has been stationed at Louisville, Kentucky, is now at Billings General Hospital, Fort Benjamin Harrison.

Captain Loren H. Martin, of Indianapolis, has been transferred to the Flight Surgeon's Office, Miami Beach, Florida. He had formerly been at Randolph Field, Texas.

Arthur E. Moravec, M.D., of Fort Wayne, has been commissioned a lieutenant, senior grade, in the United States Navy, and has reported for active duty at Farragut, Idaho.

Lieutenant Robert J. Miller, of Evansville, has been promoted to the rank of captain in the Medical Corps of the United States Army. Captain Miller is at present stationed in North Africa.

Lieutenant Frank W. Oliphant, of Mount Vernon, is now in Italy. He states in part: "The weather over here continues pleasant enough, but it gets dark very early. Once in a while some German planes come over and scare us a bit even though we know they have other objectives in mind. They claim it doesn't get very cold over here, even in winter—only a few days when the temperature gets below freezing."

Major Frederick D. Cheney, of Indianapolis, member of the medical staff of a United States Army general hospital in England, was recently appointed commander of the medical detachment of the hospital. As detachment commander he directs the activities of the trained specialists and technicians who assist the doctors and nurses in the professional services of the hospital. Major Cheney, who joined the hospital unit while the organization was stationed at Camp Bowie, Texas, is a graduate of the Indiana University School of Medicine.

Lieutenant Voris F. McFall, of Anderson, flight surgeon with the 13th Air Force in the South Pacific, has been promoted to a captain. Captain McFall was originally assigned to duty at Truax Field, Madison, Wisconsin, from where he went to the Army Air Forces School of Aviation Medicine at Randolph Field, Texas. Later he was assigned to one of the Air Force technical schools at St. Petersburg, Florida, and in April, 1943, he was sent overseas, where he not only is meeting the various problems of Aviation medicine and flying personnel, but is also encountering and gaining valuable experiences in tropical diseases.

Captain George W. Marsh, of Otterbein, writes: "I am fine these days and going strong on the training program. However, things are not too bad and I hope this thing is soon over. I have been in England now for over a year."

Lieutenant Jean Pilot, who has been with the 6th Service Command at Chicago, Illinois, has been transferred to the station hospital at Camp McCoy, Wisconsin.

Major R. S. McElroy, of Princeton, a member of the United States Army Medical Corps, recently returned for a visit with friends and relatives.

Harrison C. Ragsdale, M.D., of Bedford, has received a lieutenant commander's commission in the Medical Corps of the Navy. He will report for duty at the Naval Training Station at Farragut, Idaho, December twentieth.

Morris C. Thomas, of Indianapolis, has recently been promoted to the rank of colonel. Colonel Thomas is commanding officer of the Station Hospital at Fort Knox, Kentucky. He held a reserve commission and was called to active duty in October, 1940, with the rank of captain.

Captain Charles L. Richardson, of Rochester, has been promoted to the rank of major in the Army Medical Corps. Major Richardson is stationed at Camp Tyson, Tennessee. He recently took a course in plastic surgery in the Army Medical School at Loyola University, New Orleans, Louisiana.

Captain R. B. Smallwood, of Bedford, recently called at the office while on leave from Gulfport, Mississippi. Captain Smallwood reported that Lieutenant Emile H. Ravdin, of Evansville, is also stationed there, and that Edward C. Lidikay, of Ladoga, is now a captain.

The St. Joseph County *Service Bulletin* for October gives some interesting experiences of some of their members, from which we quote in part.

Captain Ben Firestein, of South Bend, who is serving abroad, told of having been a guest of the Pasha of Morocco. He said, "I want to tell you about the marvelous experience I had recently. Nine of us officers were invited to have dinner with the Pasha of Morocco. We went to his home at 7:30. What we could see of it in the blackout is a large estate on a cliff overlooking the ocean. We were met at the doorway of the wall by his guard, armed with curved knives, who saluted us graciously. We were escorted down a flower-bordered walk to a passageway where more guards greeted us. Then we went into a hallway (of marble, I believe) where the Pasha (called 'Your Excellency') and some of his aides welcomed us. We were intro-

duced individually by an interpreter, bowed and shook hands. Then the Pasha escorted us into a large, beautiful room partly oriental and partly very modern—furnished very fine with much furniture, ornaments, vases, hassocks, chairs and pillows all over—fine oriental rugs and tapestries, beautiful teakwood and sandalwood tables, et cetera. Very fine. We were served absinthe and ice water and drank and talked. At exactly eight o'clock we were led across an open courtyard, all in beautiful tile as we could see in the starlight, and palms and bushes everywhere, into another very beautiful room. In one corner a huge silver table, low set, was surrounded by cushions. Twelve of us—seated on cushions—sat around this large silver platter of great antiquity and fine workmanship, engraving and etching all over it. The Pasha did not sit with us, for it is the custom for him, as host, to see that the guests are taken care of; he sat at another table with some younger man whom we assumed might be his son. Whenever the servants entered the room, they first removed their slippers. On the silver platter there were twelve wine glasses and twelve beautiful glass bowls. First two servants entered carrying a large silver basin with a centerpiece in it containing a bar of soap and a large silver kettle containing water. The other carried a fine lace towel. The bowl was placed in turn under each man's hands, and we washed with soap and rose-scented water and then dried on the lace towel. When this was completed another servant entered with a large bowl of steaming soup. The aide ladled out twelve bowls of soup and we ate. It was very delicious—made from eggs and butter and meat stock and spaghetti and many different spices and condiments. We were instructed even while on the boat that when eating in a Moor's home, always leave part of your food on the plate—for the leavings are given to the family, the wives and children to eat, so we all left some soup in each bowl. The bowls were cleared away (the service is rapid) and a servant brought in hunks of bread and placed before each of us. Then a large platter bearing a whole side of roast lamb, young and tender, was set in the middle of the table. Small dishes of salt and a mixture of caraway seeds and anise seeds ground together, and I don't know what other spices were set around. Then with our hands and fingers we tore off pieces of meat and dipped them into the spices and ate. No utensils are used. We grab what we see, tear it off and eat. In the meantime our glasses were filled with wine and we drank of it. It was very good lamb, but we didn't eat too much because we knew that more was coming. Shortly this platter was taken to the Pasha for him to eat, as you see he stays one course behind us; he gets the platter after we are finished and then it goes out somewhere to the rest of the family. In the meantime the third course came in. This was a large pie fully three feet around. Again using our hands we tore into it and found that it was a chicken and egg pie.

The crust is somewhat like what we make for strudel. The pie has something sour in it and powdered sugar is sprinkled on it to sweeten it. When we have had our fill, it is taken away and course four comes in. This is a large platter with four young chickens roasted with wine sauce. These are torn up and we eat with our fingers. Then the next course is four young chickens broiled with a very delicious herb and mint sauce over them. We eat some of that and are instructed to tear bits of bread and dunk into the sauce. Course six is a large dish of what looks like lamb or mutton hock covered over with large cooked onions and vegetables. This is a sweet dish and we eat and dunk some more. Course seven consists of four roast chickens covered with cooked olives and delicious sauce. This is very good, the taste of olives is all through the meat, but naturally we are so full we eat very little. Course eight is another huge pie. This is made from dates and figs, and many sweet fruits and nuts, extraordinarily delicious, but very sweet and scented with rose water; course nine consists of large oranges and mandarins (seedless tangerines) and the meal is ended. We get up and seat ourselves on a cushioned bench which runs around the room. Hot, sweet demi-tasse is served in delicate gold and china cups, and we drink, smoke and talk. Then the servant comes back with the silver wash basin and kettle and soap, and we wash again. Then another tray is brought in. It has fifteen large drinking glasses and a large pitcher filled with a white liquid. We are told this is almond milk, made by crushing almonds. It is cold and sweet, flavored with honey and rosewater. The glasses are taken away and a tray is brought in. On it are beautiful silver flagons. These contain rosewater. One is given to each of us and we sprinkle it on our hands and massage them. Then an incense burner with charcoal is brought in and placed before the Pasha. He takes pieces of sandalwood from his pocket and places them in the burner. When the lid is put on the fragrant smoke comes out of holes in the lid. A servant picks it up and passes among the guests. We are instructed to open our blouses as he passes and the smoke is allowed to waft into our clothes. This completes the ceremony. It is after ten. We sit around and smoke cigarettes and talk, some listen only. The Pasha and his aide both are very highly educated men and speak beautiful French, but very poor English. There is much laughter at our pidgin French, one or two speak it well. I'm sorry now that I didn't follow up my French in school, but even though I gibber it I usually am understood, and if I'm spoken to slowly I can follow pretty well. About eleven o'clock we said our goodbyes and were escorted to the ambulance waiting to take us back. It was a highlight experience and those of us who were fortunate enough to be invited considered it quite an honor. Nine courses plus the accessories are given only to very honored guests by the Moors, so we feel like big shots."

WHAT WENT ON DURING WORLD WAR I

(Items from THE JOURNAL of January, 1944)

Four papers constituted the scientific section, headed by an article, "Relation of Pulse Pressure and Kidney Function to Operative Prognosis," by J. O. Polak, of Brooklyn, a guest speaker at the September meeting, as was E. I. McKesson, who spoke on "Cesarean Section and Obstetric Operations Under Nitrous Oxide Anesthesia."

Other papers were "Management of Eye Cases by the General Practitioner," by A. L. Marshall, Indianapolis, and "Anesthesia in Curriculum and Clinic," by W. D. Gatch, also of Indianapolis.

* * *

The "Flu" epidemic still was raging and two of the editorials in this number discussed matters pertaining thereto—"Influenza Relapses" and "Pneumonia Prophylaxis." Other editorials dealt with the Medical Reserve Corps, standards for the practice of medicine, and a suggestion for all-year medical schools.

In the latter connection the editor seems to have been much concerned with the difficulty that had been experienced in getting medical enlistment during World War I. This was especially true in the lower age group of physicians, men under forty-five years of age. The editorial strongly recommended the drafting of physicians in the event of another war.

* * *

The matter of promotions in the Medical Corps was an interesting subject even twenty-five years ago. It was felt that medical men who had been recommended for such promotion before leaving service should have that honor conferred upon them, even after they had been mustered out.

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The annual plea for a prompt payment of dues was being made, numerous reasons being set forth for this. It also had been discovered that some county medical society secretaries had been lax in remitting dues already paid, thus added confusion to the picture.

* * *

It was stated that a medical society in one of the southern states was trying to have the license of one of its members revoked, the charge being made that he was overcharging his patients. Editor Bulson was "agin" such a step, declaring that the fee charged was a matter of individual right.

* * *

One of the larger independent medical journals had bought up several such smaller journals. The editor was of the opinion that such a move would be worth while *if* said journal intended to keep its advertising pages *clean*. He was not at all certain, however, that this would be done, declaring that the advertising pages of this journal were "rotten."

The government had sent out an emergency call for the increased propagation of white mice, to be used for laboratory experimental purposes. The editor opined that this probably would bring forth the indignation of the anti-vivisectionists.

* * *

"With eggs six to eight cents apiece, butter seventy-five to eighty cents a pound, and everything else in the same proportion, it is well for any doctor who is getting no more for his services than he did ten years ago to 'sit up and take notice.'" Further, the editorial comment says, "The idea of unionism in the medical profession is repugnant to the average doctor, and yet there is room for the adoption of the principle of unionism which demands that medical men stand together for all that makes for the betterment of the profession, not the least of which is decent compensation for services rendered."

* * *

Among the Medical Corps officers who had been released from their duties and had returned to their homes were: Drs. W. N. Thompson, Sullivan; C. C. Collins, Roachdale; J. F. Robertson, Indianapolis; E. M. Van Buskirk, Fort Wayne; W. E. Nichols, Hammond; O. A. DeLong, Azalia; E. B. Flavian and J. L. Gilbert, Logansport; J. T. Wheeler, Indianapolis; J. A. Rawley and H. M. Pell, Brazil; C. L. Boyd and N. E. Beckes, Vincennes; B. R. Kirklin, then of Muncie; and H. H. Wheeler, Indianapolis.

* * *

J. Rilus Eastman, retiring president of the Indiana State Medical Association, had appointed a committee to make a survey of Indiana in the matter of providing interns for the various hospitals of the state.

* * *

Information had been received that Base Hospital Number 32, then stationed in France, would not be returned to this country for some time. This was also known as the Eli Lilly Base Hospital and was manned with men from the Hoosier state.

* * *

Herbert T. Wagner, of Indianapolis, was one of the first physicians to enter Germany during the war. He was one of a group of three doctors and four nurses detailed to go to Germany in advance of the occupational forces.

* * *

In the financial report of the secretary we find some interesting figures: The balance of our general fund was \$2,954.05. The rental expenses incident to the September session was \$131.90, and at that time we had paid out \$19.68 for badges and buttons.

News Notes

Dr. E. L. Fosbrink, of Elkhart, is moving to Syracuse, where he will establish his residence and practice about January first.

Dr. W. H. Johnson, of Alexandria, has gone to Detroit to fill a vacancy on the staff at the Ford Hospital.

Dr. J. M. Kercheval and his father, Dr. C. F. Kercheval, formerly of Indianola, have moved their residence to Clinton, and opened their office above White's Pharmacy.

Dr. J. L. Blaize, of Vincennes, has accepted a position as resident physician at the New Castle Hospital for Epileptics, at New Castle, and has begun his duties there.

The Welborn Hospital, in Evansville, established about a half century ago, has been sold to the First Baptist Church of Evansville. The hospital will be operated as the Welborn-Baptist Memorial Hospital, starting January first.

Malcolm E. Miller, M.D., of Goshen, who was commissioned in the United States Public Health Service in August, 1942, and has been assigned to the United States Coast Guard since, is now stationed at the United States Coast Guard Training Station, Manhattan Beach (Sheepshead Bay), Brooklyn, New York, where he was made chief of the Eye, Ear, Nose and Throat section of the U.S.P.H.S. Hospital.

Carnegie-Illinois Steel Corporation, United States Steel subsidiary, has announced the appointment of Dr. Joseph C. Donchess, of Gary, as chief surgeon of its two Gary plants. Dr. Donchess will continue to maintain headquarters in the medical dispensary at the Gary Steel Works, but also exercises supervision over the medical staff of the Gary Sheet and Tin Mill.

Dr. Cleon A. Nafe has been chosen as president-elect of the Indianapolis Medical Society at the annual election of officers, held December seventh at the Indianapolis Athletic Club. Dr. Nafe will take office in 1945. Dr. Harry L. Foreman, who was elected a year ago, will serve as president in 1944. Other 1944 officers are Dr. Gordon W. Batman, vice-president; Dr. William M. Dugan, secretary-treasurer, and Dr. Lillian B. Mueller, chairman of the Library Committee.

Dr. Evelyn Ross has resigned her internship at the Indiana Medical Center, Indianapolis, to accept an internship at Queen's Hospital in Honolulu. Dr. Ross went to San Francisco, awaiting transportation to Hawaii.

In this issue is carried an advertisement of a Mid-Winter Post-Graduate Conference to be held in Chicago at the Stevens Hotel, March 14, 15 and 16, sponsored by the Chicago Medical Society.

Highlights of the event will be announced later. For information address the Secretary, Chicago Medical Society, 30 North Michigan Avenue, Chicago 2, Illinois.

DOCTOR FISHBEIN TO ADDRESS MEETING

Dr. Morris Fishbein will talk on the Wagner-Murray-Dingell Bill, Tuesday evening, January eighteenth, at eight o'clock, at the Howard County Court House, in Kokomo, at a public meeting. This is a big undertaking for Howard County and the Howard County Auxiliary, and we must all help them to make this meeting a success. All physicians are invited!

Members of the Miami County Medical Society, in cooperation with the State Board of Health and the State Department of Education, conducted examinations of all students sixteen years of age or older enrolled in the high school. This was in connection with the physical fitness program. The examinations had been requested and are being carried out on the advice of the Army and Navy authorities, who desire that the physical condition of students this age be rechecked and the defects discovered and corrected before the student enters the military or civilian service.

Several of the county tuberculosis associations are sponsoring tuberculosis clinics, and among them we have reports from the following: The Benton County Tuberculosis Association conducted a clinic in the Fowler School Building, on December ninth, with Dr. J. W. Strayer, of Lafayette, examining physician; the Gibson County Tuberculosis Association conducted a clinic in the Elks' home, on December sixth, with Dr. Paul D. Crimm, of Evansville, examining physician; and the Ripley County Tuberculosis Association conducted a clinic in the Osgood Public Library, on November twenty-fourth, with Dr. Charles J. McIntyre, of Indianapolis, as clinician.

INDIANA UNIVERSITY NEWS NOTES

Drs. George J. Garceau and James S. Battersby, both members of the staff at the Indiana University Medical Center, have been appointed by Dean W. D. Gatch as medical supervisors of the Center's physiotherapy and occupational therapy departments.

The directorship of the two departments recently was made vacant by appointment of Mrs. Winifred C. Kahmann as superintendent of the newly-created occupational therapy unit in the reconditioning division of the Army Surgeon General's Office.

Dr. Garceau, who will have medical supervision of physiotherapy at the medical center, is associate professor of orthopedic surgery in the Indiana University School of Medicine, and since 1933 has been chief orthopedic surgeon of the James Whitcomb Riley Hospital. The Occupational Therapy Department will be under the medical supervision of Dr. Battersby, who has been resident surgeon at the center since 1940.

Dean Gatch has announced that other responsibilities heretofore assumed by Director Kahmann have been placed in charge of the following: Miss Carrol Moyer, Riley physiotherapy; Mrs. Gertrude Muench, Clinical Building physiotherapy; Miss Virginia Watwood, Clinical Building occupational therapy; Miss Dorothy Richardson, Rotary Convalescent Home occupational therapy; Miss Margret Gleave, Riley occupational therapy, and Miss Elizabeth Gallagher, administrative. The occupational therapy work in the Riley hospital is supported by the Junior League of Indianapolis, and Junior League Volunteers assist in all of the university hospitals.

Three bequests and one gift aggregating \$23,500 to the James Whitcomb Riley Hospital for Crippled Children at the Indiana University Medical Center in Indianapolis have been announced by the Board of Governors of the Riley Memorial Association.

The bequests were from three Indianapolis residents who died recently, and were as follows: Mrs. Lottie E. Hughes, \$12,000, in memory of her son, Raymond D. Hughes; Mrs. Ellis Floris Workman, \$2,500; and Mrs. Nellie Ballard Boyce, \$6,000, in memory of her sister, Claudia E. Ballard. A gift amounting to \$3,000 to be devoted to treatment and care of Washington County children sent to the hospital was made by W. B. Reyman, of Salem, in memory of his daughter, Mary Willtrude Reyman.

Hugh McK. Landon, president of the Riley Memorial Association, in announcing the bequests and gift described them as "contributions to a great scientific cause which is certain in the end to pay a rich social return in longer life and new knowledge."

One hundred and forty-eight student nurses at Indiana University's Training School for Nurses have been accepted for new United States Cadet Nurse Corps, created by the Federal government to meet the wartime shortage of trained nurses.

The Indiana University nursing school is one of the schools approved for the Cadet Nurse Corps by the United States Public Health Service. Students accepted for the Corps will be trained at government expense, but agree to remain active in essential nursing in either civilian or military service throughout the war.

ABSTRACT

STUDY SHOWS BRIGHTER OUTLOOK FOR VICTIMS OF ANGINA PECTORIS

The life expectancy after angina pectoris first appears is about twice as long as has been commonly believed, Paul D. White, M.D.; Edward F. Bland, M.D., Boston, and Edward W. Miskall, M.D., East Liverpool, Ohio, report in *The Journal of the American Medical Association* for November 27. This statement is based on what is, so far as they know, the first study of this condition that involved a large series of cases followed over an adequate length of time.

The three physicians made a follow-up study in 1943 of 497 cases of angina pectoris that were first observed in the years from 1920 to 1930. Of the 497 patients, they say, "445 are dead and 52 are still living. The average duration to death of the 445 was 7.9 years, while the average duration from onset of the disease in the living is 18.4 years. The average duration to date for the combined dead and living is 9.0 years, which will ultimately increase when all the present survivors succumb, doubtless to a figure approximating ten years, a duration of life about double that at present widely regarded as the

expectation of life after angina pectoris first appears [five years or less]. Seventy-six per cent of the deaths were due to cardiac causes. . . . A pronounced degree of nervous sensibility was a favorable influence [in survival]. Angina pectoris decubitus was found in 103 (20.6 per cent) of the 497 cases. There were no significant differences in the average duration of the disease to death or in the living between this group and that of the group as a whole. . . ."

The three men point out that it is not only helpful for the doctor to know something of the average life expectancy in general in angina pectoris but also "for the patient himself and for his family, rather than to leave merely the impression that prediction is impossible and that the Sword of Damocles may fall at any moment. Such a state of affairs is for many persons so paralyzing that they are prone to sit for many years awaiting the end, unable to carry on a useful or happy life, or else, hardened by the thought, they may lead a reckless existence which can in truth hasten their end.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Membership Report

Number of members Nov. 13, 1943	3,324*
Number of members Nov. 13, 1942	3,236
Gain over last year	88
Number of members Dec. 31, 1942	3,259

* Includes 124 honorary members and 916 men in service who received membership gratis.

Treasurer's Office

The committee approved the usual expenditure for the annual audit of the books. This audit will be made so that the report will be ready for the midwinter meeting of the Council.

Statements of receipts and expenditures for August, September and October for the Association committees and for September and October for THE JOURNAL were approved.

1943 Annual Session, Indianapolis, September 28 to 30, 1943

Instructional Courses. These were an unusual success. The Executive Committee suggests that Dr. Gordon Batman, general chairman for the 1943 meeting, attend the next meeting of the Executive Committee to discuss instructional courses for 1944.

A letter of appreciation is to be written to Dr. Batman, thanking him and his committee for the splendid work they did in arranging the 1943 meeting, with particular commendation for the instructional courses.

The annual report of the Executive Committee and the supplemental report calling for further study of group malpractice insurance were approved by the House of Delegates.

The citizenship resolution which was passed at the last meeting of the House of Delegates was brought to the attention of the Executive Committee. The comment in regard to Canadian physicians was also brought to the attention of the committee.

Commercial Exhibits. Letter received from Howard Carter, secretary of the Council on Physical Therapy of the American Medical Association, shows that at least half of the exhibitors at the Indiana State Medical Association are displaying products in violation of the rules of the Council

on Pharmacy and Chemistry. It is understood that most of the state societies are exhibiting these products.

Pepys' Diary in Indiana. The committee felt that Dr. McCaskey had answered Dr. Morris Fishbein adequately.

1944 Annual Session, Indianapolis

Tentative dates set for the meeting are Tuesday, Wednesday and Thursday, October 3, 4 and 5, 1944.

Appointment of general arrangements chairman to be made for 1944 meeting.

Preliminary report upon arrangements for 1944 meeting to be ready for midwinter Council meeting on January 9, 1944.

Legislative, Legal and Social Security Matters

National

Report made that Joint Resolution 159, appropriating \$18,620,000 for the extension of obstetrical and pediatric care of service men's families had been passed by Congress.

Action of the House of Delegates in regard to obstetrical and pediatric care brought to the attention of the committee, along with a letter from the Howard County Medical Society concerning the action taken following the state meeting.

Wagner-Murray-Dingell Bill. A letter from Dr. Olin West in regard to the present status of the bill, resolutions passed by the House of Delegates of the Indiana State Medical Association, and resolutions and actions taken by other states brought to the attention of the committee.

Articles by the following proponents of the bill brought to the attention of the committee:

- a. Waldemar Kaempffert—article in *American Mercury*.
- b. Paul deKruif—*Kaiser Wakes the Doctors*.
- c. Labor groups.
- d. CIO.

Opponents of bill:

- a. State medical associations.
- b. Insurance companies.
- c. Indiana State Chamber of Commerce. (Clarence Jackson's talks and pamphlets.)
- d. Resolution of Tippecanoe County Medical Society. (To be sent to all county medical societies in the country.)
- e. Pharmaceutical group.

Methods of combatting Wagner-Murray-Dingell bill in Indiana:

- a. Inter-Professional Health Council.
- b. Use of Woman's Auxiliary.

Madison County Auxiliary has had a meeting at Anderson to discuss the bill.

The Howard County Auxiliary is arranging for a public meeting on the bill at Kokomo on January 18.

c. Physicians speakers' bureau. Each councilor is to name three or more speakers in his district who will be prepared and available to make talks in the communities of the district upon the Wagner-Murray-Dingell Bill. The morning session of the Secretaries' Conference, to be held January 23, 1944, will be devoted to the coaching of these speakers. Dr. F. S. Crockett, of Lafayette, has made numerous talks upon this bill, and his method of approach is to be suggested to speakers.

Tolan Bill. Hearings upon this bill which would allow chiropractors to be used in United States compensation cases are now being held in Washington.

Federal funds for relocation of physicians. Action upon this is now pending before Congress. The Public Health Service is asking for \$4,427,550.00 for this purpose. Of this sum \$2,350,000.00 will be used in malaria and venereal disease control programs "for the protection of troops stationed in the Caribbean area, and for the supplying by the Public Health Service, on request of state authorities, of needed medical and dental care, either by temporary financial aid or by direct employment of doctors and dentists, in certain critical areas where acute shortages have developed which cannot be met without recourse to emergency measures."

Local

Chiropractic and cult situation. Chiropractors are busy organizing for the 1945 session of the legislature.

Misuse by cultists of Army training pamphlet entitled "Take Your Tip from the Army," by Major Henry I. Szymanski, physical training and athletic officer, 33rd Infantry Division, United States Army, brought to the attention of the committee. This pamphlet is printed by the Victory Publishing Company, 111 W. Jackson Boulevard, Chicago, and it is being distributed by drugless healers to their patients with a yellow insert, also printed by the Victory Publishing Company, stating, "The way in which the Army is giving special attention to the spinal column and natural methods is causing naturopathic patients to place even more confidence in their naturopaths, if such could be possible. . . . Go to your naturopath today . . . and if defects are found, have them corrected immediately."

Public Relations

The Executive Committee approved the action of the editor of THE JOURNAL, calling special attention to the resolution passed by the House of Delegates of the Indiana State Medical Association in regard to Public Relations.

Copies of the communication from the new Council on Public Relations of the American Medical Association distributed to members of the committee. The committee noted particularly that nothing in this communication indicated that the Public Relations Council would proceed with the establishment of a Washington office. An informal statement in regard to how Indiana intends to cooperate with the Council approved by the committee.

Suggested organization of the Indiana State Medical Association to coordinate and emphasize Public Relations is to be prepared by the executive secretary for presentation to the committee at its next meeting.

Letter from Dr. Louis Bauer, chairman of the new Council on Medical Service and Public Relations, in regard to the resolution presented to the House of Delegates by Lake County concerning Public Relations brought to the attention of the committee.

"The Indiana Contact Plan," originated and presented to the American Medical Association in 1934 by Dr. R. L. Sensenich, brought to the attention of the committee. The committee approved the reintroduction of this plan, along with the pamphlet prepared by Clarence Jackson of the Indiana State Chamber of Commerce against the Wagner-Murray-Dingell Bill, at the secretaries' conference at Chicago.

Organization Matters

The committee approved the purchase by the Indiana University Library, upon behalf of the state medical association, of a book entitled, "Surgical Errors and Safeguards," by Max Thorek, M.D. This book is to be placed in the library in memory of Dr. Rilus Eastman, past president of the state medical association.

Committee appointments for 1944. Dr. Oliphant is to have these appointments in the headquarters' office by December 1.

Medical Economics

It is not necessary for physicians to pay store tax, according to action taken by the Store License Division of the State of Indiana. This question was brought to the attention of the committee as one physician in the state had mistakenly been instructed to pay a store tax by an agent of the Store License Division.

War Medicine

The members of the War Participation Committee had a joint meeting with the members of the Executive Committee and Major Glen Ward Lee, secretary of the committee, made a report upon the following subjects:

New Selective Service Medical Survey Program. In this program a report is made upon each male high school student, age fifteen years and over, at the time he leaves school. This program also

calls for a search of the records of the State Department of Public Welfare for every registrant when he is placed in 1-A class to determine whether the registrant has been committed to a state mental institution. Major Lee stressed the fact that every effort was to be made against the violation of professional confidence.

Intern and Resident Training Program. Inequities of this program as they pertain to certain Indiana hospitals discussed by the committee. The committee is to communicate with the national Directing Board of Procurement and Assignment Service and point out these inequities.

State Board of Health

Obstetrical and Pediatric Care of Service Men's Families. Letters received at headquarters' office since the state meeting in regard to this problem have been referred to the Advisory Committee to the Bureau of Maternal and Child-Health of the Indiana State Board of Health, headed by Dr. Nolting.

Group Hospitalization and Voluntary Health Insurance

Resolutions passed by the House of Delegates approving group hospitalization and voluntary health insurance brought to the attention of the Executive Committee. A committee is to be appointed to study the various plans now in operation and present "the best plan for consideration of the Council." Among the states approving such plans are Ohio, Michigan, Wisconsin and West Virginia.

State Board of Medical Registration and Examination

Opposition of the Howard County Medical Society to the annual registration of physicians brought to the attention of the committee. As the House of Delegates of the Indiana State Medical Association at its last session voted in favor of annual registration, the secretary was instructed to write the Howard County Medical Society that opposition to the annual registration of physicians' resolution passed by the House of Delegates should be brought to the attention of the House of Delegates at the next annual session.

Future Medical Meetings

November 15 to 19—Southern Medical Association, Cincinnati. President and secretary to attend.

November 19 and 20—Secretaries' Conference, American Medical Association, Chicago. President, editor of THE JOURNAL, and secretary to attend.

January 9, 1944—Midwinter meeting of the Council.

January 23, 1944—Secretaries' Conference, Indiana State Medical Association.

The program for the secretaries' conference was discussed by members of the Committee on Secretaries' Conference and the Executive Committee. Decision made to have a morning session devoted to an instruction course for speakers against the Wagner-Murray-Dingell Bill.

The Journal

The committee approved taking the advertising from the Wine Advisory Board as in the past, upon the motion of Dr. Weyerbacher, seconded by Dr. Oliphant.

Printing contract for 1944 with C. E. Pauley and Company approved by committee.

Many requests received from over the country for a copy of the article entitled, "Anatomical Dissection of Paul deKruif's Book *Kaiser Wakes the Doctors*," by Dr. Floyd T. Romberger.

Medical Defense

Group Malpractice Insurance. Dr. Nafe made a further report on this subject.

There being no further business, the meeting was adjourned.

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

November 4, 1943.

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D.; R. E. Jewett, M.D.; Mrs. Lotys Stewart, and T. A. Hendricks, executive secretary.

Preliminary outline for radio program presented by the radio script writer and commented upon by the representative from the State Board of Health. This program is to be carried on jointly by the State Board of Health and the Indiana State Medical Association.

A program for future newspaper releases was presented and received the general approval of the Bureau.

Reports on medical meetings:

Oct. 18—Indiana Pharmaceutical Association, Indianapolis. "Wagner-Murray-Dingell Bill." (15 present.)

Oct. 18—Woman's Auxiliary to the Madison County Medical Society, Anderson. "Wagner-Murray-Dingell Bill." (75 present.)

Nov. 4—Board meeting, Woman's Auxiliary to the Indiana State Medical Association, Indianapolis. "The Part the Woman's Auxiliary Is to Play in the Battle against Socialized Medicine and the Defeat of the Wagner Bill." (24 present.)

Requests for speakers:

Dec. 2—Annual meeting of Indiana Township Trustees, Indianapolis. Executive Secretary of the Indiana State Medical Association to speak.

Dec. 17—Indiana Health Council. Speaker to discuss the Wagner-Murray-Dingell Bill.

Jan. 18—Woman's Auxiliary to the Howard County Medical Society, Kokomo. Speaker to talk on Wagner-Murray-Dingell Bill.

Letters are to be sent to each councilor asking that suggestions be made of physicians who may be able to speak in public meetings on the Wagner-Murray-Dingell Bill.

Letter received from Mrs. Frank Cregor which read as follows:

"A few days before THE JOURNAL came, I was looking for something in my files and picked up the history of the Woman's Auxiliary founding or organization, written two or three years ago for the National Historian. I wonder if your office might like to have that record? It contains a list of charter members and first-year members. Some day someone will write the Indiana history of the Auxiliary as someone is now writing the history of the Association. It was organized in 1927; we had our first formal meeting at Gary in 1928—just fifteen years ago! About ten years from now there will be a scramble for data as the Auxiliary celebrates its silver anniversary! How well it has grown in the years. And what excellent space it now has in THE JOURNAL!"

The Bureau feels that this is material of historic value and should not be lost.

Letter received from the director of the Bureau of Health Education of the American Medical Association in regard to radio transcriptions. Much material will be available from the American Medical Association for the radio program in this state.

BUREAU OF PUBLICITY

November 26, 1943.

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D., and T. A. Hendricks, executive secretary.

The following newspaper releases were approved for publication:

"Food Fights for Health Too."

"Heart Diseases in Children."

The executive secretary reported upon his conference with the director of the Bureau of Health Education of the American Medical Association concerning radio broadcasting.

Future medical meetings:

January 9, 1944—Midwinter Council meeting.

January 23, 1944—Annual Indiana Secretaries' Conference.

January 30, 1944—Secretaries' Conference of the Michigan State Medical Society.

Report on medical meeting:

October 12, 1943—Vanderburgh County Medical Society, Evansville. "The Wagner Act in Relation to the Medical Profession." (75 present.)

Woman's Auxiliary program for 1943-1944 approved by the Bureau.

INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

(Abstract of minutes of meeting held at the Indianapolis Athletic Club, Indianapolis, on Tuesday, November 23, 1943.)

The Indiana Inter-Professional Health Council is composed of five representatives each from the Indiana State Medical Association, the Indiana State Dental Association, the Indiana Pharmaceutical Association, the Indiana Hospital Association, and the Indiana State Nurses Association, together with the Secretary of the State Board of Health, the Dean of the School of Pharmacy of Purdue University, the Dean of the Indianapolis College of Pharmacy, the Deans of the School of Medicine of Indiana University at Bloomington and at Indianapolis, and of the School of Dentistry, Indiana University. The Indiana State Veterinary Association was also represented at the meeting.

A spokesman for each organization expressed the attitude of his organization toward passage of the Wagner-Murray-Dingell Bill (S. 1161) (H. R. 2861), which deals with social legislation. It was concluded that complete unanimity of opinion against passage of the proposed legislation in its present form existed among the members of the Indiana Inter-Professional Health Council and the organizations represented.

It was decided that the Council should take steps to help disseminate information against both the Wagner-Murray-Dingell Bill and the Kilgore Bill, and try to stimulate study of the two bills, both by groups and individuals. Both bills, if they become law, would regiment certain groups, thus placing an ever-increasing power of government over individuals, and tending to eliminate individual initiative and competition.

After other business was considered, Chairman Glenn L. Jenkins, Dean of the School of Pharmacy, Purdue University, was re-elected Chairman of the Council for the ensuing year, and Harry L. Kendall, Purdue University School of Pharmacy (a representative of the Indiana Pharmaceutical Association), was elected Secretary-Treasurer.

LOSE EITHER WAY

There's no use. If you make out your income tax return wrong, you are in the hands of the law; if you make it out right, you are in the hands of the receiver.—*Rotary Bulletin*.

OLD FRIEND

An Army prospect taking his physical examination was asked by the doctor if he could read the fourth line on the eye chart.

"Read it?" exclaimed the prospect. "Why, I know the guy personally. He played right guard for Fordham last Fall."—*Rotary Hub*.

COUNTY SOCIETIES

COUNTY MEDICAL SOCIETY OFFICERS

ADAMS COUNTY MEDICAL SOCIETY:

President, Gerald J. Kohne, Decatur
Vice-president, James M. Burk, Decatur
Secretary-treasurer, Myron L. Habegger, Berne

BOONE COUNTY MEDICAL SOCIETY:

President, Alvin D. Schaaf, Jamestown
Vice-president, R. J. Harvey, Whitestown
Secretary-treasurer, John R. Porter, Lebanon

ELKHART COUNTY MEDICAL SOCIETY:

President, Ralph H. Young, Goshen
Vice-president, M. F. Hunn, Elkhart
Secretary-treasurer, O. E. Wilson, Elkhart

GRANT COUNTY MEDICAL SOCIETY:

President, Leon J. Garrison, Gas City
Vice-president, John A. Ritchey, Marion
Secretary-treasurer, Russell W. Lavengood, Marion

GREENE COUNTY MEDICAL SOCIETY:

President, Frank A. VanSandt, Bloomfield.
Vice-President, William F. Craft, Linton.
Secretary-Treasurer, George E. Moses, Worthington.

HUNTINGTON COUNTY MEDICAL SOCIETY:

President, Harold S. Brubaker, Huntington
Vice-president, Harold F. Bonifield, Warren
Secretary-treasurer, Grover Nie, Huntington

KOSCIUSKO COUNTY MEDICAL SOCIETY:

President, Theodore Scott Schuldt, Pierceton
Secretary-treasurer, L. A. Laird, North Webster

LA PORTE COUNTY MEDICAL SOCIETY:

President, Louis Moosey, Union Mills
Vice-president, M. D. Gardner, Michigan City
Secretary-treasurer, Robert M. Kelsey, La Porte

MADISON COUNTY MEDICAL SOCIETY:

President, C. S. Wright, Anderson.
Vice-President, R. O. Zierer, Anderson.
Secretary-Treasurer, M. A. Austin, Anderson.

NOBLE COUNTY MEDICAL SOCIETY:

President, B. H. Pulskamp, Wolcottville.
Vice-President, Kenneth Sneary, Avilla.
Secretary-Treasurer, Frank W. Messer, Kendallville.

SULLIVAN COUNTY MEDICAL SOCIETY:

President, Marion H. Bedwell, Sullivan
Vice-president, Antha A. Hamilton, Shelburn
Secretary-treasurer, J. S. Brown, Carlisle

WAYNE-UNION COUNTY MEDICAL SOCIETY:

President, Louis Francisco Ross, Richmond
Vice-president, Curtis R. Hoffman, Richmond

WABASH COUNTY MEDICAL SOCIETY:

President, Fred M. Whisler, Wabash
Vice-president, James G. Kidd, Roann
Secretary-treasurer, O. G. Brubaker, North Manchester

LOCAL SOCIETY REPORTS

100% IN PAYMENT OF 1944 DUES

Huntington County

Posey County

Cass County Medical Society members held a meeting at the Cass County Hospital on November sixteenth. Dr. Robert E. Jewett, of Indianapolis, was the guest speaker.

Clay County Medical Society members held a meeting at Aydelotte's, at Brazil, on November sixteenth. Following the meeting the group congregated at the home of Dr. Fred C. Dilley. Eight members were present at the meeting.

Delaware-Blackford County Medical Society members held a meeting at the Ball Memorial Hospital, at Muncie, on November twenty-third. The twenty members in attendance discussed measures to combat the Wagner-Murray-Dingell Bill.

Elkhart County Medical Society members held a meeting at Hotel Elkhart on December second.

Fort Wayne (Allen County) Medical Society members met on November second. Dr. K. C. Eberly, Dr. Samuel R. Mercer and Dr. Paul P. Bailey, all of Fort Wayne, and all members of the City Board of Health, spoke.

Three medical officers of Baer Field presented the program for the meeting on November sixteenth, at the Chamber of Commerce. A display of field medical equipment was made following the discussion.

Dr. Robert S. Berghoff, of Chicago, a cardiologist, was the speaker at the meeting on November thirtieth, in the Chamber of Commerce.

Hancock County Medical Society members, with their wives as guests, were entertained at a turkey dinner at the Christian Church on November seventeenth. The speaker of the evening was Dr. Thurman B. Rice, of the Indiana State Board of Health.

Jay County Medical Society members and hospital staff held their regular monthly meeting on November nineteenth at the hospital. "Safe Obstetrics versus Haphazard Guesswork" was the subject.

Lawrence County Medical Society members held their final meeting of the year 1943 at Dunn Memorial Hospital on December first. The luncheon was followed by a business session, which was highlighted with the annual nomination and election of officers for the ensuing year. A windup of business matters for the present year concluded the program.

Miami County Medical Society members held a meeting at the Bearss Hotel, at Peru, on November twenty-sixth. O. U. Carl, M.D., of Peru, read a paper on "Croupous Pneumonia." Dr. Carl's paper included excerpts from a lecture which he heard Sir William Osler give in person. Ten members and five guests were present at the meeting.

Lake County Medical Society members comprising the Industrial Health Committee were favored with a visit by Dr. M. F. Johnson, assistant secretary of the Council on Industrial Health of the American Medical Association. Dr. Johnson spoke on the ways and means of controlling industrial absenteeism in the Calumet area by health measures.

Randolph County Medical Society members met at the Elks Club, at Union City, on December sixth, for a Christmas dinner and election of officers. The program consisted of case reports and a talk by Dr. Charles E. Martin, of Lynn, on the subject of "Poliomyelitis."

St. Joseph County Medical Society members met in the Indiana Club on November twenty-ninth. The subject of their discussion concerned the proposed \$1,500,000 hospital for crippled children. The members also discussed socialized medicine as it affects the profession.

Wabash County Medical Society members met at the Woman's Clubhouse for a dinner meeting on November third. Routine business was discussed.

On December first, members were entertained at the Sheller Hotel, in North Manchester. A Christmas turkey dinner was served and musical selections were rendered by a violin trio. A business session followed the dinner, with election of officers for 1944. The society went on record as approving the Tippecanoe County Medical Society resolution on state and socialized medicine.

Indianapolis (Marion County) Medical Society members held a meeting at the Indianapolis Athletic Club on December seventh. The annual election of officers was held. The various society committees that have been active during the year presented their annual reports.

On December fourteenth a meeting was held at the Indianapolis Athletic Club. The program for this meeting was provided by the Medical Department of the United States Navy, under the direction of Captain R. H. Collins, Senior Medical Officer, Naval Air Station, Bunker Hill, Indiana. "Epidemic Cerebrospinal Fever" was discussed by Lieutenant Commander J. B. Crost and "Experiences with the Pacific Fleet Before, During and After Pearl Harbor" by Lieutenant D. L. Martinson.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. James Baxter, Jr., New Albany
President-elect—Mrs. F. M. Gastineau, Indianapolis
Corresponding Secretary—Mrs. John Habermel, New Albany
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis

We want to take this opportunity to welcome a new auxiliary to our state association. Hancock County was recently organized by Mrs. F. B. Wishard, of Pendleton. Mrs. J. E. Ferrell, of Fortville, is president of the new group.

NOTICE TO COUNTY PRESIDENTS

Please do not fail to have your secretary mail a report of each meeting to the State Chairman of Press and Publicity. The national chairman requires a report from each state chairman at the end of the year.

MRS. A. B. RICHTER, *Chairman*
Press and Publicity Committee

ALLEN COUNTY

Major Phillip Rossman, of the Baer Field Medical Unit, spoke on "Military Medicine" at the November meeting of The Woman's Auxiliary to the Allen County Medical Society, at the home of Mrs. D. F. Cameron.

MARION COUNTY

The wives of medical officers stationed at Billings General Hospital, Fort Benjamin Harrison, Camp Atterbury and Stout Field were guests of The Woman's Auxiliary to the Marion County Medical Society at a tea given at the Governor's Mansion on November fifteenth. About 125 members and guests were in attendance. There were 35 guests, and they came from all parts of the United States.

VIGO COUNTY

The Woman's Auxiliary to the Vigo County Medical Society held a meeting November first at the home of Mrs. Harvey B. Decker. The day was spent in sewing for the Bundles for America and for the Red Cross. A short business session was held in the morning and a cooperative luncheon was served at noon. Members brought stuffed animals for the benefit of the occupational therapy department at the hospitals.

HYGIEA

This is the time of year that your husbands are renewing their subscriptions to *Hygiea*. See that *your* auxiliary gets credit for his subscription.

"The common man will readily lend himself to socializing schemes, for in such programs he dissolves his inferiority sense in the mob. Oliver

Wendell Holmes commented crisply after visiting one of the Utopians' schemes of his age, 'Everything was common there but common sense.'

"The uncommon man will instinctively rebel against socialization, for its sole purpose is to reduce him to the colorlessness of the crowd. Socializing and stylizing medical practice will serve to make it a dull job, and against this it is your destiny as uncommon men to fight with all your soul and spirit. If the day ever comes when medicine is trimmed down to a cheap and prosaic commodity, it will not be necessarily very poor, but by no means will it be very good. It will certainly be very common, and commonness is the one poisonous ingredient which will certainly destroy it as an art."

(From Dr. Louis L. Karnosh's remarks in an address at the 100th Anniversary of Western Reserve University Medical School.)

RESOLUTION ADOPTED BY THE MICHIGAN STATE MEDICAL SOCIETY

The House of Delegates of the Michigan State Medical Society, at its session of September 20-21, 1943, adopted the following resolution by unanimous vote:

"RESOLVED, That the House of Delegates of the Michigan State Medical Society instruct its delegates to the American Medical Association House of Delegates to support and fight for the principles enunciated by the several states in resolutions which were aimed to establish in Washington, D. C., a bureau of information to aid members of Congress (in order to defeat attempts to lower the standards of the practice of medicine in the United States), and be it further

"RESOLVED, That The Council of the Michigan State Medical Society be instructed to contact all other State Medical Societies for the purpose of implementing this objective."

LAKE COUNTY DOCTORS LAUNCH MOVE TO FIGHT UNITED STATES CONTROL OF MEDICINE

"A group of Lake County physicians announced today organization of a national medical group pledged to refuse participation in any program such as that proposed by the Wagner-Murray-Dingell bill.

"The incorporation, not for profit, of the Association of American Physicians and Surgeons, was announced by Rollen W. Waterson, executive secretary of the Lake County Medical Society and, temporarily, of the new association.

"He said the association also would 'co-operate in the establishment of voluntary plans for insurance protection against the costs of sickness.'

"Waterson said plans are to organize physicians throughout the nation to block the 'regimentation of American medicine under compulsory systems of bureaucratic Federal control such as proposed by the Wagner-Murray-Dingell Bill.'

"Under the by-laws of the new organization,' he said, 'members agree to refuse participation in any scheme regarded as opposed to the best interests of patient and physician. By this means, and through their refusal to associate professionally with physicians who do participate, systems of politically-controlled medicine could not function because there would not be sufficient doctors to provide the service.'

"The Wagner bill provides for salary levies upon employers and employes to furnish hospitalization and medical care administered by federally appointed physicians, the entire program to be directed by the surgeon general of the United States Public Health Service."

(Reprinted from the Indianapolis Star of December 29, 1943.)

RESOLUTION ADOPTED BY DELEGATES OF WESTERN STATE MEDICAL ASSOCIATIONS

December 11, 1943—Salt Lake City, Utah

RESOLVED, That it is the sense of the representatives of the western states medical associations that an organization be created to maintain a service bureau in Washington, D.C., for the purpose of informing governmental agencies and representatives with regard to public health matters affecting the western states and to inform the medical profession of all federal government activities affecting the profession; and be it further

RESOLVED, That other state medical associations be invited to join with the western states in a nation-wide program of this character; and be it further

RESOLVED, That, temporarily, the organization be called the "Western States Public Health League" and be composed of the eleven western state medical associations until a permanent constitution and by-laws are adopted.

THE NEW ENGLAND OPINION

A turbulent deluge of words has been set loose by Senator Wagner's new idea of Utopia by legislation. Medical societies across the land have gone on record and passed resolutions of condemnation that are spirited, if not always logical, and the *Journal of the American Medical Association* has said, in installments, that all is right with medicine in America, in fact it is so near perfection it should not be disturbed. That is on one side. On the other, the ex-bacteriologist, Mr. DeKruif, who will write on almost any subject at the drop of a hat and just to keep the game going drops his own beret now and again, has written a book that had quite a vogue on the Washington trains for a while. The pontifical space writer, Waldemar Kaempffert, has contributed whenever space and rates can be found and Henry Kaiser, who builds ships, has a fool-proof 7½¢ a day plan for medical care that if time is taken to figure it out would only cost three and a half billion dollars a year. Senator Murray has mounted the rostrum to explain that the Wagner Bill does not really mean all that it seems to mean, and that militant little band of wise men, the Committee of Physicians, was quick to write Senator Wagner a letter of congratulation and approval.

In all this flood of confused and confusing opinion a solid rock of clear thinking is found in the statement from the medical societies of New England that is published in this issue of the JOURNAL. With characteristic forthrightness New England admits that medical care can and should be made more readily and economically available for all people. The insurance principle for providing medical care is endorsed and a special plea is made that if government is to intervene it should be for the poor who have no income from which a 6 percent tax can be collected, and who seem to be forgotten. The statement holds no selfish fear about what may happen to the profession as a career if it comes under government control, but it does express alarm as to what will become of the quality of medical care if it becomes the plaything of politics.

The document has been prepared for the self-reliant people of New England and their representatives in the Congress of the United States and offers the experienced wisdom of medical counsel to aid in the development of a program of social betterment in the American tradition without revolutionizing the habits of independence. It is from a beginning such as this that substantial progress should be made. The proposal is surely not unique, for physicians everywhere must have thought of it and asked why it has not been done before. Perhaps attempts have been made and not borne fruit, but if that is the case medicine and the public should know it. And if every effort has not been made to bring about a cooperative understanding between those responsible for medical care and those responsible for government, medicine has the right to know why.—*Reprinted from Connecticut State Medical Journal of December, 1943.*

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COOK COUNTY GRADUATE SCHOOL OF MEDICINE

(In affiliation with COOK COUNTY HOSPITAL)
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ANNOUNCES CONTINUOUS COURSES

SURGERY—Two Weeks Intensive Course in Surgical Technique starting January 10th, and every two weeks throughout the year.

MEDICINE—Courses to be announced in January.

GYNECOLOGY—Two Weeks Intensive course starting February 7th. Clinical Course.

OBSTETRICS—Two Weeks Intensive Course starting February 21st.

ANESTHESIA—One Week Course in Continuous Caudal Anesthesia for Obstetrics.

OPHTHALMOLOGY—Clinical Course.

OTOLARYNGOLOGY—Special and Clinical Courses.

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UROLOGY—Two Weeks Course and One Month Course available every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address: Registrar, 427 South Honore Street
Chicago 12, Illinois

(The following letter is reprinted from *The Journal of the American Medical Association* of December 11, 1943.)

THE WAGNER-MURRAY-DINGELL BILL

Open Letter of Massachusetts Medical Society to Its Representatives in Congress

[This open letter has been sent to the Massachusetts representatives in Congress. It is expressive of the point of view of the Massachusetts Medical Society, a point of view which is shared with the Medical Societies of Maine, New Hampshire, Vermont, Rhode Island and Connecticut, with regard to Senate Bill 1161 and House Bill 2861, the so-called Wagner-Murray-Dingell bills.]

Dear Sir:

The Massachusetts Medical Society, in conjunction with the Medical Societies of Maine, New Hampshire, Vermont, Rhode Island and Connecticut, has studied Senate Bill 1161 and House Bill 2861 now before the Congress of the United States and respectfully submits its views on this proposed legislation.

We approve of the broad medical objective of the Act that we interpret to be an attempt to improve the health of our people. As a basis of our approval we cite the progressive leadership which the physicians of New England have always shown in the development of public health enterprises. For more than fifty years we have consistently supported the plea for the establishment of a National Department of Health with a secretary in the President's cabinet, under whom would be coordinated many important public health programs, exclusive of the Army and Navy. These are now scattered through various departments and bureaus of the federal government and already play a large role in the provision of medical care for the people of this country.

We approve of the use of the insurance principle on a voluntary basis as a means to aid the individual to budget against the cost of medical care. We maintain that, when insurance programs are not directly under the supervision of the medical profession by whom medical care is to be rendered, they should provide for cash benefits to be paid to the individual, for we firmly believe that the citizens of New England are capable of using cash benefits to pay the cost of medical care.

We believe that S. 1161 and H. 2861 do not provide for the sound development of a national health program. It is implied by the Act that the distribution of compulsory savings managed by

federal authorities will guarantee better health for all of the people. We sincerely doubt that such an objective can be realized in this way. In the New England states, judged by any standards with which we are familiar, there is no need to revolutionize the habits of the people in their methods of obtaining medical care.

Private enterprises in the field of voluntary prepaid medical and hospital insurance are increasing rapidly. These facilities should be utilized by the states, if necessary through federal grants-in-aid, so that each state can purchase medical care for those who cannot purchase it for themselves. This we believe to be a development that would be acceptable to the New England people, for thereby medical care could be provided even for the indigent, who are public charges, a provision most desirable in those communities that have been unable or unwilling to meet this obvious responsibility.

We shall be glad to work out plans with representatives of the federal and state governments to improve the health of all the people, but we should expect that any plans that might be devised would take full advantage of existing agencies and be developed within the social patterns that are well understood by our people.

Very truly yours,

Michael A. Tighe, M.D.
Secretary.

Roger I. Lee, M.D.
President.

ABSTRACT

SUGGESTS VOLUNTARY CONTROL OF PATENT MEDICINE ADVERTISING

The time seems ripe for more positive voluntary control by American newspaper publishers of the more blatant advertisements of proprietary remedies in order to avoid the danger of control by governmental decree such as has taken place in Argentina. *The Journal of the American Medical Association* for December 4 suggests in commenting on a recent action taken by the publishers of London, England, newspapers aimed at bringing under control such advertising abuses. *The Journal* says:

"The better newspapers in this country for years have attempted to exclude the more blatant advertisements of proprietary remedies. A few—too few—have even banned advertising of this class altogether. In Britain, where the situation with regard to extravagant claims has been generally much worse than here, a long step forward has just been taken. As told elsewhere in this issue, London newspapers, through their trade association, voluntarily have adopted regulations which should greatly improve the standard of control over such advertising claims. In this country too the time seems ripe for more positive voluntary action by publishers to

AN INVITATION TO THE MEDICAL PROFESSION OF INDIANA

Post-graduate Mid-winter Conference at the Stevens Hotel, Chicago, March 14, 15, 16, 1944, sponsored by the Chicago Medical Society. Daily scientific programs, scientific and commercial exhibits. Full details in February.

avoid the danger of control from above by decree, as in Argentina where almost complete government control of drugs and drug advertising has been established [reported in the same issue of *The Journal* by its regular Buenos Aires correspondent]."

In the same issue of *The Journal*, its regular London, England, correspondent reports that:

"Blatant claims to cure all sorts of diseases made in the newspaper advertisements of proprietary medicines have long been a scandal. At last, this practice is to be checked. The Newspaper Proprietors Association has unanimously adopted the following rules: 1. No advertisement will be accepted for any medicine or treatment which is claimed to be effective in Bright's disease, cancer, tuberculosis, diabetes, epilepsy, fits, locomotor ataxia, disseminated sclerosis, osteoarthritis, spinal, cerebral and venereal diseases, lupus or paralysis or for preventing any of these ailments; for the cure of amenorrhea, hernia, blindness, rheumatoid arthritis or any ailment of the auditory system; for procuring miscarriage; for the treatment of habits associated with sexual indulgence, or for any ailment connected with these habits. 2. No advertisement will be accepted from any advertiser who by printed matter, orally or in his advertisement, undertakes to diagnose any condition or to receive a statement of any person's symptoms with a view to advising or providing for treatment by correspondence. 3. No advertisement will be accepted containing a testimonial other than one limited to the actual views of the writer, or any testimonial given by a doctor other than a recognized British medical practitioner. 4. No advertisement will be accepted containing illustrations which are distorted or exaggerated to convey false impressions. 5. No advertisement will be accepted which may lead persons to believe that the medicine emanates from any hospital or official source, or is any other than a proprietary medicine advertised by the manufacturer for the purpose specified, unless the advertising agent submitting the copy declares that the authority of such hospital or official source has been duly obtained.

"These rules are now in operation in all of the London morning, evening and Sunday newspapers. Also all advertisements will be submitted to medical scrutiny and the products advertised to chemical analysis if this is considered necessary. This is the first time leading newspapers have unanimously laid down and insisted on a standard of control over claims made in advertisements."

INDIANA STATE MEDICAL ASSOCIATION DIVISION OF COMMUNICABLE DISEASE CONTROL Monthly Report, November, 1943

Diseases	Nov. 1943	Oct. 1943	Sept. 1943	Nov. 1942	Nov. 1941
Tube:culosis, Primary	14	1	3	0	3
Tuberculosis, Active.....	128	326	88	74	110
Tuberculosis, Arrested.....	26	42	19	13	8
Chickenpox	314	205	32	292	325
Measles	407	186	39	74	63
Scarlet Fever	265	281	79	189	378
Smallpox	9	2	0	8	3
Typhoid Fever	2	12	10	4	12
Whooping Cough	111	109	171	104	142
Diphtheria	67	66	26	30	98
Influenza	65	28	17	48	143
Pneumonia	26	34	23	96	52
Mumps	115	49	20	131	26
Polio:myelitis	2	27	37	8	15
Cerebrospinal Meningitis....	13	23	5	2	5
Trachoma	1	1	0	0	1
Tularemia	2	0	0	3	6
Rubella	8	4	4	5	3
Malaria	3	12	1	0	2
Undulant Fever	5	8	6	1	4
Vincent's Angina	1	0	0	7	0
Erysipelas	1	0	0	0	0
Encephalitis Lethargic.....	2	2	0	0	0



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\$25.00 weekly indemnity, accident and sickness per year

\$10,000.00 accidental death For **\$64.00**
\$50.00 weekly indemnity, accident and sickness per year

\$15,000.00 accidental death For **\$96.00**
\$75.00 weekly indemnity, accident and sickness per year

**ALSO HOSPITAL EXPENSE FOR MEMBERS,
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41 years under the same management

\$2,418,000.00 INVESTED ASSETS
\$11,750,000.00 PAID FOR CLAIMS

\$200,000 deposited with State of Nebraska for protection of our members.

Disability need not be incurred in line of duty—benefits from the beginning day of disability.

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OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1021 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

FEBRUARY, 1944

NUMBER 2

SULFONAMIDE THERAPY IN BRUCELLOSIS

A Review of Literature

DAN L. URSCHER, M. D.

MENTONE

When the sulfonamides first appeared it was entirely natural that they would be tried in brucellosis, inasmuch as it was a disease of bacterial origin which had shown some response to other chemical therapy. The first publication appeared in the European literature in 1936, and in the following years there were a number of articles on the subject. However, the number of cases covered was small, and there usually were no control studies. In the preparation of this paper the writer has reviewed all of the English and American articles, and several of the French and German ones. This includes only forty-nine articles on human brucellosis, covering a total of one hundred ninety-five cases. It may be seen from this that the amount of clinical material on the subject is very small.

It is the writer's intention in this paper to present, first, a discussion of experimental work with the sulfonamides and brucella organisms; second, a discussion of the results in human beings as tabulated from these forty-nine publications; and lastly, a number of letters from leading authorities in the field setting down their personal opinions regarding this. For simplification of publication the entire bibliography is not listed, but any desired bibliographic data will be supplied by the writer.

EXPERIMENTAL BACKGROUND

There was general agreement in all of the seven articles reviewed on this phase of the subject. The sulfonamides showed a definite bacteriostatic activity and even a bacteriocidal one in vitro, but the in vivo action was not nearly so constant. Chinn¹ showed that if he started the sulfonamide therapy at the same time he infected his animals the treatment was very successful, but that if the infection

had an opportunity to become localized in any manner the drugs were ineffective. Hamann and Huddleson² showed that sulfapyridine had little if any effect on the course of the infection. Working with other sulfonamides, workers were unable to prove any definite and constant protection.

The experimental basis for the sulfonamide treatment of brucellosis may be briefly summarized by stating that there has appeared no definite proof of the beneficial action of the drugs in experimental animals except where the medication may be started very early and in large doses.

RESULTS IN HUMAN BEINGS

In Table I the complete series is analyzed on a basis of drug used and success attained. The headings, complete success and complete failure, are self explanatory, but the relapse column should be discussed. Many of these cases were successfully treated by the same drug in the relapse period. Some of them had two, three, or even four relapses. However, most of them were eventually successfully treated, either with sulfonamides or with sulfonamides and vaccine, so that if one is inclined to be more charitable toward the results of drug therapy, the percentages in complete success and in relapse might be added to make a successful treatment column.

It is worthy of note in Table I that the percentage of success and failure did not vary greatly with the different types of medication. This is particularly true in the first three, which cover most of the series and are for that reason more significant.

The results listed under sulfaguanidine are of interest, although the mode of action is certainly unproved; the series is too small to be of great

¹Chinn, B. D.: The Use of Sulfanilamide in Experimental Brucellosis, *J. Inf. Dis.*, **64**:78-82 (Jan.-Feb.) 1939.

²Hamann, E. E., and Huddleson, I. F.: Effect of Sulfapyridine on *Brucella Abortus* in vitro and in vivo, *Proc. Soc. Exper. Biol. and Med.*, **42**:555-556 (Nov.) 1939.

TABLE I
ANALYSIS OF RESULTS FROM THE VARIOUS SULFONAMIDES

Drug	Cases	Complete Success		Failure		Relapse	
		No.	%	No.	%	No.	%
Sulfanilamide	112	66	58.9	34	30.4	12	10.7
Injectable Prontosil	41	21	51.2	13	31.7	7	17.1
Oral (Neo-) Prontosil	26	16	61.5	4	15.4	6	23.1
Sulfaguanidine	3	3	100.0				
Sulfathiazole	6	2	33.3	2	33.3	2	33.3
Miscellaneous	7	3	42.8	1	14.3	3	42.8
Totals	195	111	56.9	54	27.7	30	15.4

TABLE II
TO SHOW THE RESULTS OBTAINED WITH DIFFERENT STRAINS OF THE ORGANISM

Organism	Cases	Complete Success		Failure		Relapse	
		No.	%	No.	%	No.	%
Suis	2	2	100.0				
Abortus	6	4	66.7	2	33.3		
Melitensis	30	6	20.0	16	53.3	8	26.7

value, and there were no controls. Sarvis,³ who reported these cases, has informed the writer in a personal communication that he has since treated one other patient with sulfaguanidine with equal success.

Table II is presented to analyze the cases according to causative organisms. It is of interest in showing that the melitensis strain of the organism seems to be most resistant to sulfonamide therapy. This has also been borne out by experimental work.

The presence of a positive blood culture seems to have no particular effect on the eventual outcome, as outlined in Table III.

Of the 195 cases reported, 140 were acute, and 55 were chronic. Determination of results in chronic cases is often difficult, but Horn,⁴ who has reported most of these, informed the writer in a recent letter that he felt that about 50 per cent of the patients had been benefited.

In evaluating therapy in acute brucellosis, the disappearance of fever is generally considered as a sign of success. Of the 111 successful cases reported in this review, 36 were analyzed in sufficient detail to allow tabulation of results. This data is included in Table IV. Acute brucellosis is generally a self-limited disease with a duration of

five to seven weeks. It may be seen in the 22 cases listed under sulfanilamide therapy that the average treatment was begun at five weeks, and the patient was fever-free a week later. Without adequate control, such results cannot be unequivocally accepted.

Table V lists the method of diagnosis in 77 cases. It may be seen that the agglutination test was positive in a high percentage of these, and the blood cultures were positive in a somewhat higher number than is normally expected. As regards the skin test and the opsonic index, this table must not be taken to show that these tests are of little value in the diagnosis of acute brucellosis inasmuch as they were infrequently used in the diagnosis in these cases. If every one of the 77 had been given a skin test, and only 11.7 per cent were positive, it would be of importance, but this table merely tabulates the means used in diagnosing these cases. In 9 of them the skin tests gave a positive reaction, and this was included in the diagnostic confirmatory data. The actual percentage of positive and negative skin tests is not obtainable, nor is the percentage of opsonic index reactions.

PRESENT OPINION

Letters were written to several of the leading workers on the subject, asking for their opinions regarding its present status. Dr. I. F. Huddleson says, "From my observations and the information I have obtained in letters from more than 100 physicians, there is only one conclusion that I can

TABLE III
RESULTS IN CASES WITH POSITIVE BLOOD CULTURE

Organism	Cases	Complete Success		Failure		Relapse	
		No.	%	No.	%	No.	%
Suis	2	2	100.0				
Abortus	6	4	66.7	2*	33.3		
Melitensis	5	1	20.0	3	60.0	1	20.0

* Both were proved as *Brucella Abortus* endocarditis at autopsy.

³ Sarvis, E. S.: The Treatment of Brucellosis by the use of Sulfaguanidine, *Northwest Medicine*, **41**:208-209 (June) 1942.

⁴ Horn, Will S.: Sulfanilamide in the Treatment of Undulant Fever, *Texas State J. Med.* **36**:232-237 (July) 1940.

TABLE IV

DETAILS OF THERAPY, AS TO DURATION OF ILLNESS AND OF TREATMENT, IN THIRTY-SIX SUCCESSFUL CASES

<i>Drug</i>	<i>Cases</i>	<i>Average age</i>	<i>Average duration of illness before therapy</i>	<i>Average days of fever after therapy started</i>
Sulfanilamide	22	38 yrs.	34.1 days	7.5 days
Injectable Prontosil	1	6	7.0	10.0
Neoprontosil oral	7	31	56.8	10.5
Sulfaguandine	3	19	46.0	3.3
Others	3	24	68.6	27.3

TABLE V

DIAGNOSTIC DATA IN SEVENTY SEVEN ACUTE CASES

Total Cases	Agglut.		Skin Test		Opsonic Index		Blood Culture	
	No.	%	No.	%	No.	%	No.	%
77	72	93.5	9	11.7	3	3.9	13	16.9

draw pertaining to the therapeutic value of the sulfa drugs in brucellosis. Thus far they have failed as therapeutics. This is true in animal brucellosis as well as human brucellosis."

Dr. David T. Smith, professor of bacteriology at Duke University, states, "Our experience has shown that sulfanilamide and the other sulfonamides are very helpful in the treatment of acute brucellosis when the patient has agglutinins in his blood, or when he develops agglutinins within a week or ten days after the sulfonamide therapy is started. In those patients who seem to be unable to produce agglutinins we have never seen any signs of improvement as a result of sulfonamide therapy."

Lee Foshay, M.D., in a detailed discussion of the subject, was critical of the methods of study so far reported. He points out the characteristic relapsing nature of the disease, and states, "It is my opinion that we have not had the sulfonamides long enough to estimate their worth in the treatment of brucellosis."

Dr. Charles Armstrong, a worker with Dr. Alice Evans, and Chief of the Division of Infectious Diseases of the United States Public Health Service, wrote, "I happen to know, however, that it is Dr. Evans' feeling that there is no convincing evidence of encouraging results having been attained insofar as she is aware."

Dr. Will S. Horn reported a large series of chronic cases treated with sulfonamides several years ago, and it was of interest to see what he thought about it at the present time. His opinion, which was previously mentioned in this paper, is quoted: "Most of my experience has been with cases of chronic undulant fever, but an analysis of the cases treated three or four years ago indicated that about 50 per cent of the patients appeared to be definitely improved."

COMMENT

It may be seen from the statistics and opinions herein presented that the value of sulfonamide therapy in brucellosis is as yet unproved. It is impossible to form any valid opinion from such a small series of cases, but the weight of the evidence would seem to be on the side of those who

feel that the sulfonamides are not indicated in the treatment of human brucella infections. Brucellosis is a disease characterized by spontaneous remissions and relapses, and any form of therapy must be evaluated with this in mind. When the first reports on sulfonamide therapy appeared in the literature, they were almost entirely favorable, but each author reported only a few cases (usually one) with a follow-up observation period of never more than a year, and usually only a few months. As more complete reports appeared it was seen that not only was the percentage of complete success less than it first appeared, but the number of relapses was significant. Inasmuch as the sulfonamides are toxic drugs it would seem that their use in brucellosis is questionable. Brucellin and vaccine have been tried over a period of many years and proved successful in much larger numbers of cases than have been included in the sulfonamide reports. Their indications and contra-indications are definite, and the low toxicity is proved. If any valid opinion can be presented from the preceding data, it would be this: there is no evidence at the present time that the sulfonamides are of enough benefit in the treatment of human brucellosis to warrant their use.

CONCLUSIONS

1. All of the English language literature on the subject of sulfonamide therapy in brucellosis, up to March 1943, is reviewed.
2. One hundred ninety-five cases are listed with 56.9 per cent complete success, 27.7 per cent complete failure, and 15.4 per cent initial success with later relapse.
3. These publications cover only the work as far as sulfathiazole and include nothing on sulfadiazine or later derivatives.
4. There is no evidence to prove that one sulfonamide is more valuable than any other in this disease.
5. Inasmuch as the actual percentage of successful therapy is no higher than might be expected from untreated cases of this disease, the conclusion must be drawn that the value of sulfonamide therapy in brucellosis is doubtful.

A VENEREAL DISEASE EPIDEMIC IN A RURAL COMMUNITY

LYMAN D. EATON, M.D.*

PRINCETON

The purpose in writing this paper is to set forth a narration of activities and to review our records and experiences with a venereal disease epidemic occurring in a rural area. Prior to some months ago the author's medical experience had been confined to urban areas; consequently his recent experience with a rural venereal disease epidemic was quite new. It is hoped that certain facts observed in connection with the epidemic may be of interest to others who may labor under the illusion that venereal disease in any large proportion is primarily confined to large urban areas.

The area under consideration is a typical, rural, American town with a population of approximately eight thousand persons. It boasts no unusual industrial or commercial districts. It enjoys a smattering of industry, some commercial enterprise and a large farm element. A point of interest in connection with the town, which probably has a definite correlation with the epidemic, is that the town enjoyed "boom activities" due to the construction of a large federal project.

In Table I it is readily shown that during the six-month period from May 1, 1943, through October 31, 1943, a total of seventy-six new cases of venereal diseases were discovered in this community. These were brought to the attention of the local public health venereal disease clinic; therefore, they do not represent the sum total of all venereal diseases occurring in the community during this period of time. Communications with local physicians revealed that they had seen approximately twenty-five new venereal disease cases which are not included in the above table. The twenty-five patients who consulted private physicians were seen in a six-week period from June 15, 1943, to August 31, 1943, and it is regrettable that figures from the local physicians are not available for the entire six-month period covered by this study, nor are the figures which the local physicians submitted classified; consequently, they cannot be incorporated in this study. The facts as shown in

Table I do not reflect a very pretty picture for the community, but when one considers that these figures do not obviously represent the sum total of all venereal disease cases discovered in this community during the six-month period, the picture is even more alarming. It would be safe to estimate that the local physicians saw as many venereal disease cases during the six months as did the clinic. An interesting observation to be made from Table I is that 51 of the 76 cases were infected with gonorrhea and 25 with syphilis. A closer observation of the gonorrheal cases will show that 29 of the 51 occurred in single females, as compared to only 8 cases in single males. The total number of females infected with gonorrhea was 40 as compared with 11 males. This is almost a 4 to 1 ratio, which is approximately the same ratio which prevailed between single females and single males. When the total gonorrheal and syphilitic cases are studied, the ratio is not quite so large—47 females and 29 males. A fact, possibly of some interest but not shown in the above table, is that 4 of the patients were infected with both gonorrhea and syphilis. No clear-cut answer for this wide variation in sex distribution of venereal diseases in this present epidemic is at the moment available. Part of the answer may be that there is a greater proportion of females in the community than males, which is the result of many of the men being in the armed forces. Another explanation is that the disease is more readily recognized in the male. Also, it may be that the men today, generally speaking, have greater available funds than do the women; consequently, they may seek treatment earlier. Another answer might be that females are likely to be chronically infected and in many cases asymptomatic; consequently, they were brought to light only as a result of contact tracing.

Of the 76 cases tabulated in Table I, 32 were diagnosed on the basis of clinical, laboratory, and history findings; 8 on clinical and laboratory; 12 on clinical and history; 14 on laboratory and history, and 10 on laboratory findings only. Those

TABLE I
NEW VENEREAL DISEASE CASES CLASSIFIED BY SEX AND MARITAL STATUS

MAY 1, 1943—OCTOBER 31, 1943

Type of Disease	FEMALE		Total Female	MALE		Total Male	Total Male and Female Patients
	Single	Married		Single	Married		
Gonorrhea	29	11	40	8	3	11	51
Syphilis	3	4	7	5	13	18	25
Total	32	15	47	13	16	29	76

* Director, District Health Department No. 1, Princeton, Indiana.

TABLE II

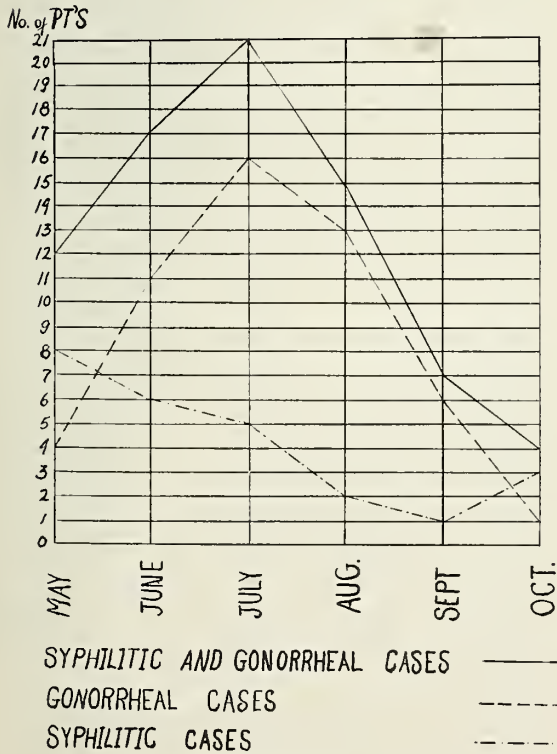
NUMBER OF NEW CASES DISCOVERED BY MONTHS

MAY 1, 1943—OCTOBER 31, 1943

Type of Case	May	June	July	August	September	October	Total
Gonorrhea	4	11	16	13	6	1	51
Syphilis	8	6	5	2	1	3	25
Total	12	17	21	15	7	4	76

cases in which a diagnosis was made on laboratory findings only were cases of syphilis, and these were diagnosed only on repeated positive serological tests. It is regrettable that clinical, laboratory, and history findings could not be proved in each case, but because of inadequate local laboratory facilities in such a rural area repeated laboratory tests could not always be run in order ultimately to secure positive laboratory findings. In the absence of positive laboratory findings no diagnosis of venereal disease was made except when a positive history and obvious clinical findings were present. The failure to get adequate history in each case was due to the uncooperative attitude and unwillingness of many patients to admit their promiscuity and, in fact, some often denied any history of contact whatsoever despite their obvious infection.

NUMBER OF NEW VENEREAL DISEASE CASES DISCOVERED
BY MONTHS
MAY 1, 1943--OCT. 31, 1943



GRAPH I

A study of Table II will reveal the months in which the new venereal disease cases were discovered. There is nothing particularly alarming about the time the syphilitic cases occurred. The number of syphilitic cases, it is true, increased very slightly during the interval from June through August. The increase was not sufficiently great to arouse concern, but when one looks at the number of new gonorrheal cases which occurred it is apparent that they increased suddenly and in an unusually large number during the months of June through August. The gonorrheal cases discovered during June through August constituted a fraction over 78 per cent of the total cases of gonorrhea occurring in the six months under study. If thought is concentrated on both syphilitic and gonorrheal cases it is seen that the increase in number began in May rather than June and continued through August. Eighty-five and five-tenths per cent of the total 76 cases occurred during May through August. Reference to Graph I, which was prepared from facts tabulated in Table II, will furnish a visual picture of the increase in the venereal disease rate for the period under consideration. This graph will portray more clearly than the table the fact that the peak load of new cases was reached in July, and that syphilis was not on the increase.

The question which immediately presents itself is the reason for so great an increase in the gonorrheal rate during the months of June, July, and August. Two major factors were probably partially responsible for this condition. One was the initiation of a construction project, started in May and completed sometime in August. This project brought to the town a great number of transient male workers and their women followers, the peak of the influx being in July. The second contributing factor was a very noticeable and unusually large number of soldiers who were seen to frequent the town practically every night. The soldiers obviously found interest in this community for one reason only, since there are no recreational facilities whatsoever except two small-town theaters.

To determine the amount of time required to effect an apparent cure in the majority of gonorrheal patients, the number of days required in each case was tabulated and then cases were classified in groups of ten-day intervals. The above table clearly shows that from 20 to 90 days were

TABLE III
TIME REQUIRED FOR APPARENT CURE IN GONORRHEAL CASES
MAY 1, 1943—OCTOBER 31, 1943

Days Required for Apparent Cure	11 to 20	21 to 30	31 to 40	41 to 50	51 to 60	61 to 70	71 to 80	81 to 90	91 to 100	101 to 110	111 to 120	Total
Number of Patients	2	2	5	3	3	4	3	3	0	0	1	26

required to effect an apparent cure in many patients. Of the 26 patients who have been released as apparently cured, 23, or 88.4 per cent, fell into this time interval of 20 to 90 days. The average time required to effect an apparent cure was 54.7 days. This average is unfavorably influenced by one case which required 118 days; therefore to arrive at a more accurate figure the average was again computed with this one case omitted and under these conditions it was found that 52.2 days was the average time required to effect an apparent cure.

At this time 13 of the gonorrheal patients who cannot be regarded as cured have been under treatment for varying periods of time ranging from 39 to 135 days—the average being 87.5 days and, of course, it is not known just how many more days will be required before they can be released. Twelve of the 51 gonorrheal patients elected to take treatment from private physicians or moved to other health jurisdictions after having been under treatment in the clinic for a few days;

consequently, results of treatment in these cases are not included in this study.

In order to present the weekly cumulative treatment load of gonorrheal patients, Graph II was prepared. It is readily seen from this graph that the maximum number of patients under treatment at any one time was reached in the latter part of August. A comparison of Graph I and Graph II will reveal that, although the peak load of new cases was reached in July, the treatment load was not reached until considerably later. This would indicate very definitely that a prompt cure was not readily achieved; otherwise patients would have been dismissed almost as rapidly as new patients were acquired, which is shown by these two graphs not to have been the case.

The therapeutic procedures employed in the gonorrheal cases consisted of chemotherapy, local treatments in the clinic and when necessary in the home, and in a few cases foreign protein injections were tried. When first seen, patients were started on sulfathiazole, 60 grains daily, for a period of five days. The same dosage was then repeated on second and third five-day periods, if indicated. It can be seen from Table III that the majority of the patients were required to take sulfathiazole for more than 15 days. After having given sulfathiazole in this dosage for three 5-day periods, it was felt inadvisable to continue such large doses when dealing with persons in an out-patient clinic; therefore the dosage was reduced to 45 grains daily, and if the patient did not respond within a very short period of time, it was finally reduced to 30 grains daily. In 5 of the patients sulfathiazole reactions were observed. These cases varied in severity from a patient showing only a mild dermatitis to a patient who was quite ill with urticaria, chills and fever, arthralgia, conjunctivitis, and a drug dermatitis. None of the female patients infected with gonorrhea responded satisfactorily on chemotherapy alone, so local treatment was also employed. In the clinic concentrated negatan was applied to the cervical canal and the vagina was irrigated with 10 per cent negatan. In addition to this local treatment the female patients were instructed to take daily douches at home, except for a period of sixty hours before returning to the clinic when no douches were to be employed. The therapeutic agents used for the douches varied. In some cases lysol was used, and in others vinegar was used. It is recognized that other medicinal agents might

GONORRHEAL CASE LOAD DURING EPIDEMIC
BY WEEKS
MAY 1, 1943—OCT. 31, 1943



TABLE IV
NEW CASES CLASSIFIED BY AGE GROUPS
 MAY 1, 1943—OCTOBER 31, 1943

AGE GROUPS BY YEARS							
Type of Cases	1-12	13-17	18-24	25-30	30-35	35 & Over	Total
Gonorrhea	0	14	20	7	2	8	51
Syphilis	1	0	3	7	9	5	25
Total	1	14	23	14	11	13	76
Percentage of Gonorrheal Cases	0	27.4%	39.2%	13.7%	3.9%	15.7%	100%
Percentage of Syphilitic Cases	4%	0	12%	28%	26%	20%	100%

be superior to either of these, but in view of the class of patients generally seen in the clinic it was impossible to expect them to purchase expensive medication. Furthermore, to require them to purchase medicine for the treatment of a condition which they frequently felt did not exist would have created an even more uncooperative spirit. Many female patients stated that they felt perfectly all right and thought that there was nothing wrong with them, and they disliked very much having to submit to treatment for a condition which they, in their own minds, believed did not exist. Local treatment was unnecessary in the case of the male except for two cases where argyrol injections were used. Foreign protein injections were tried in three instances but were of no therapeutic value. The therapeutic measures left much to be desired, but conditions prevented the adoption of a more satisfactory regime. No doubt, it would have been preferable to have seen these patients at least twice, and in some cases three times, weekly and local laboratory facilities would have been very helpful, but unfortunately neither of these were attainable.

Several factors entered into the picture which made for the prolonged treatment time. One of these was the treatment schedule of weekly intervals. Undoubtedly, observation and treatment at more frequent than weekly intervals would have materially reduced the therapeutic interval. A second factor was the attitude of many patients to ignore, at least in part, the instructions given them relative to the method of taking medications, abstinence from alcoholic beverages, and the avoidance of sexual excitement. It is known that a few of the individuals did not take their medicine as directed; for example, dosages were missed repeatedly or the medicine would be carried and never taken. Other instructions were not followed, as is evidenced by the fact that it was necessary to place 7 patients in absolute quarantine—some in their homes, others in the county jail, two in an isolation hospital—and 14 were placed under provisional quarantine. Investigation of two of the persons violating provisional quarantine revealed them to be itinerant women practicing prostitution in a local hotel. They plead guilty in court and were given sentences on charges of prostitution. The need to invoke quarantine regulations in so many cases seems to be evidence

enough to indicate the uncooperative spirit of a large number of the infected persons, and this attitude undoubtedly was responsible, in no small part, for the long treatment periods.

Since so much is heard today about the "victory girls" and juvenile delinquency, the cases in this study are classified by age groups and the findings set forth in Table IV. A study of this table will show that 27.4 per cent of all gonorrheal cases occurred in patients between 13 and 17 years and that 66.6 per cent were in the age group from 13 to 24 years. A further interesting side light is that 7 of the 11 married females who had gonorrhea were young girls married to military personnel whom they had not seen for a long period of time. The greatest number of syphilitic cases occurred in individuals over 25 years of age. This is explained by the fact that very few early cases of syphilis were seen. The majority of the individuals infected with syphilis had had the disease for a period of 4 years or longer. Most of the syphilitic cases were detected through Selective Service and health certificate examinations. The facts shown in Table IV would seem to bear out the general knowledge that juvenile delinquency is definitely on the increase and must be considered as a major problem when attempting to control venereal diseases.

The venereal disease cases under study were discovered through information from various sources, as can be seen from Table V. Of the 76 cases, 24 were contacts named by civilians. Eighteen others appeared at the clinic for treatment on their own initiative. These 18, without a doubt, would have been reported sooner or later as contacts. The whispered publicity associated with the epidemic was probably the motivating force which caused the 18 to report of their own free will to the clinic. By combining the 24 reported civilian contacts and the 18 who reported of their own volition, it is seen that 42, or 55 per cent, of all cases were discovered through civilian contacts. The above facts indicate that promiscuity seems to be unquestionably incriminated as an important cause in the spread of venereal diseases. Patients were interviewed and asked to name possible sources of contact from whom they could have contracted the disease or to whom they may have transmitted it. It is realized that information secured in this way was fragmentary but, never-

TABLE V
SOURCES OF INFORMATION RESULTING IN DISCOVERY OF CASES
MAY 1, 1943—OCTOBER 31, 1943

<i>Sources of Information Reporting Individuals</i>	<i>Gonorrhea</i>	<i>Syphilis</i>	<i>Total</i>
Civilian contacts	20	4	24
Soldier contacts	2	0	2
Self	15	3	18
Civil agencies and authorities.....	7	1	8
Health certificate examinations.....	5	2	7
Physicians	1	1	2
Husband or wife.....	1	2	3
Selective Service.....	0	12	12
Total	51	25	76

theless, it did reveal 82 civilian and 26 military personnel contacts who had been exposed. It is extremely interesting that 26 military personnel had been exposed, and yet during this period only 2 reports of venereal disease, originating from this area, were received from encampments of the armed forces. This could indicate several things: either the military personnel are using their prophylaxis effectively, or they are not reporting venereal infection, or lastly, authentic sources of infection are not reported. It is hardly conceivable that 26 military exposures would result in only 2 infections. Twenty-six military contacts is a very conservative figure when one considers that during the peak of the epidemic a large number of soldiers were seen on the streets of this town every night for a number of weeks. It is highly improbable, with the promiscuity that seemed to prevail in this community, that no more than 26 military contacts would have taken place. Contact information was secured from infected girls, and they may not have known the names of the military personnel or they may have seen fit to withhold the names in many instances.

DISCUSSION

Although this article would be incomplete without at least some comment upon the various factors which may have had an influence on this epidemic, it is a foregone conclusion that one cannot, in all probability, know or consider all of the various casual relationships. Social and educational background, home environment, and restless traits which, under the present war conditions, have affected all American people have, no doubt, had no small part in contributing to the venereal disease epidemic. These factors are difficult if not impossible to investigate and analyze. There are, however, certain forces which appear to have a direct effect in precipitating the epidemic. If proper steps are taken to control these forces, future epidemics could be prevented. One very pertinent factor was the influence of the transient workers and their women followers, and the overcrowded housing facilities in this community. The transient workers, for the most part, were individuals who had little interest in the sad experiences of youth. These workers were socially irresponsi-

ble and were not possessed with any qualities which conformed to accepted social standards. A community experiencing "boom-town" conditions, as this one did, should take steps to control the activities of their local young people to insure that they do not become entangled with the transient workers who have no concern in the misfortunes their irresponsible actions may cause to the community youth. In this connection the community would do well to see that adequate recreational facilities are provided, which would offer opportunities for the transient workers as well as the local citizens to wholesomely employ their leisure hours. The community under consideration has literally no recreational facilities. For example, there is no local swimming pool, no municipal golf course, no tennis courts, ball diamonds, horse shoe pitching courts, hiking clubs, skating rinks or supervised dance floors. The only source of entertainment, aside from the two theaters, are two small privately-owned dance floors that are along the highway outside the municipal limits. Another factor probably is the utter lack on the part of many parents to properly advise, educate, and supervise their children. On occasion where lectures were given to two groups of citizens on venereal diseases and the local problem, they seemed attentive and interested but the speaker had the feeling that the majority of listeners assumed the attitude that such an unfortunate condition as a venereal disease could not occur in their family. Such a frame of mind on the part of the citizens as a whole is deplorable and probably presents one of the greatest obstacles in the way of a successful venereal-disease control program. One of the most effective instruments in an adequate venereal-disease control program would be to properly educate the adults and also the youth on the subject of venereal disease—how it is acquired, how it is spread, its complications, and the difficulty in securing satisfactory cures. Such an educational program must, if effective, be stimulating enough to arouse the people into more than a passive interest in the problem.

The practice of some physicians, fortunately few in number, to fail to accept their responsibility in the care of venereal disease patients and to

inadequately treat such cases may also be an important factor in the spread of the disease. Physicians who dislike treating venereal disease cases should not hesitate to refer infected individuals to physicians who are willing and competent to care for venereal disease patients. Such patients should be kept under treatment until definitely cured. Releasing them too soon creates a false sense of security in the patient's mind, resulting in further spreading of the disease because the individuals fallaciously believe themselves free of infection.

If venereal diseases are to be adequately controlled, the misunderstanding on the part of the people which has unfortunately been created by many human-interest stories concerning the merits of sulfonamide therapy in producing a cure of gonorrhea in a few days must be corrected. Such stories have created in the minds of far too many people the erroneous belief that gonorrhea is no longer to be taken seriously, for by taking sulfa drugs for a few days the disease can be easily and completely cured. It is even more unfortunate that some members of the medical profession seem to be deluded in their thinking that gonorrhea can be so easily cured. Reputable physicians have been known to give gonorrheal patients, particularly the female, without any examination, enough sulfa drug to last them ten days. These patients were dismissed after taking the 10-day supply of sulfonamides without any laboratory work being done. Generally speaking, the opinion of the medical profession is that gonorrhea cannot be cured so readily, particularly in the case of the female. Facts observed in connection with the epidemic and already discussed in previous pages bear out this general opinion.

The local law-enforcing agencies were in every case very helpful and cooperative in trying to bring the epidemic under control, but such agencies cannot alone effectively bring about venereal-disease control. Such control can only be accomplished through the cooperation of the law enforcing agencies and health authorities, by adequate recreational facilities and by an enlightened and determined citizenry who will do all within its power to help stamp out the disease.

CONCLUSION

1. Venereal disease epidemics do occur in rural communities.
2. Gonorrhea, generally speaking, and most certainly in times of epidemics, cannot be cured early and easily under present methods of operating rural public health clinics.
3. If public health clinics are going to properly, adequately, and successfully treat gonorrhea, they should be designed to treat patients more frequently than once a week, should have a full-time physician for at least a definite number of days each week, and should have more adequate local laboratory facilities.
4. Rural communities should provide adequate recreational facilities where leisure time could be more profitably employed, and thereby give the youth of the community less opportunity to think in terms of situations which predispose to venereal disease.
5. So long as parents take the attitude that venereal disease cannot strike in their family, there will always be a difficult obstacle to overcome in venereal-disease-control programs, which will be definitely detrimental to the effectiveness of any program.

ABSTRACT: SAY TREATMENT OF HIGHLY FATAL HEART DISEASE SEEMS PROMISING

The apparently successful treatment by use of penicillin in conjunction with heparin, an anticoagulant, of 7 patients with subacute bacterial endocarditis, a condition almost invariably fatal, is reported by Leo Loeve, M.D., Philip Rosenblatt, M.D., Harry J. Greene, M.D., and Mortimer Russell, Brooklyn, in *The Journal of the American Medical Association* for January 15.

"Further observation will be required to determine the permanence of results, but the immediate effects suggest uniformly successful sterilization of the blood and relief of clinical manifestations," the four men say.

The penicillin was given in requisite dosage by the method of the continuous intravenous drip but 1 patient also received it by injection into a muscle.

Heparin was deposited beneath the skin in most instances but occasionally was given by injection into a vein.

Six of the 7 patients suffered from a bacterial endocarditis that was engrafted on a chronic rheumatic inflammation of a valve of the heart, and the other had a congenital heart defect. In 5 of the 7 patients the organism causing the condition was a *Streptococcus viridans*; the sixth patient had a hemolytic streptococcus and the seventh a pneumococcus type 27.

In a few of the patients the efficacy of the therapy may have been enhanced by the preliminary use of sulfonamide (given to all 7 patients).

"In experimental thrombotic bacterial endocarditis," the authors explain, "the disappearance of vegetations requires the use of a suitable chemotherapeutic agent and an anticoagulant. The clinical application of this principle in subacute bacterial endocarditis has been disappointing; the technics of therapy are cumbersome, the toxicity of treatment has been excessive even for an otherwise fatal disease and the successes have been few and irregular. Early efforts made with sulfonamides, with or without heparin, have been mostly abandoned. The introduction of penicillin proved equally disappointing; the commission appointed by the National Research Council has already reported unfavorably and discouraged the use of the at-present inadequate supply of the drug for the treatment of viridans endocarditis. . . ."

In the same issue of *The Journal* Louis N. Katz, M.D., Chicago, and Captain Stephen R. Elek, M.C., A.U.S., report that "In 4 cases of combined heparin and chemotherapy, either sulfonamides or sulfonamides and intensive arsenotherapy in the treatment of subacute bacterial endocarditis due to *Streptococcus viridans*, the results were entirely negative, no evidence of clinical recovery being seen. . . . In view of this experience and that of others reported in the literature, it is concluded that the further use of heparin in subacute bacterial endocarditis should be abandoned."

ENCEPHALOPATHY FOLLOWING MASSIVE ARSENOTHERAPY*

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Cerebral involvement must constantly be borne in mind with all forms or methods of arsenotherapy, whether standard dosage routine or massive intensive method. Encephalitis, often of the hemorrhagic type although less rare, has been a frequent cause of treatment deaths. Too often in the past few ambulatory treated cases have been closely enough observed, or reactions or post treatment sequelae been reported to the attending physician or clinic that their incidence has been unknown or underestimated. Massive treated patients have been more closely studied and followed and more untoward reactions have been reported in the last several years. Early symptoms, such as headache, vertigo, nausea, emesis, personality changes, and confusion up to convulsions, must be regarded seriously. Recognized early and dealt with accordingly, fatality may be avoided. Important among the angles of therapeutic approach are repeated spinal drainage, moderate but sufficient sedation to control convulsive seizures, and dehydration by intravenous medication. The following case history is presented.

June 18, 1941—R. Mc. (ICH No. 151887) white, male, aged 36, married, was referred by Doctor R. Arbuckle for five-day intensive treatment, with complaint of rash on body, sores in nose and mouth, weight loss and positive serology.

Past history—While the patient was in another hospital for hemorrhoidectomy in January, 1941, he suddenly broke out with firm, elevated, whitish lesions on back, shoulders, face and arms, accompanied by neuralgic pains in the same area. A diagnosis of herpes zoster was made, and serologic tests for syphilis were negative at this time. These lesions gradually involuted, leaving pigmented areas. The patient continued to lose weight, did not feel well and in March, 1941, rechecked serology was still negative. A sore appeared in the right nostril and was followed by a sore throat in May, 1941. Some two or three weeks later a mouth lesion, a penile shaft lesion, and brownish colored spots appeared on the face and arms. Patient denied any extramarital contacts the previous nine months and gave no history of genital lesion until in the past two weeks. Wife was clinically and seronegative.

Past personal history was irrelevant concerning illnesses, but he gave an indefinite history of fainting spells associated with fear of pain, such as experienced on going to the dentist. He stated

that he always knew before he fainted, had no warning cry or aura but felt himself "passing out"; says he did not bite his tongue nor have convulsive seizures, and felt normal immediately on regaining consciousness. These seizures first occurred at irregular intervals about fifteen years ago, but had not been frequent the past few years. The mental and nervous, gastro-intestinal, genito-urinary and family history were all non-informing.

Physical examination—Patient was a well developed male, white, and weighed 155 pounds. His color was poor, with numerous pigmented, slightly depressed macular lesions, discrete, scattered over face, shoulders, back, arms, abdomen and legs, following no definite pattern, and in addition there were slightly elevated brownish lesions which apparently were more recent. No palmar or plantar lesions were present. There was an annular crustaceous elevated lesion in the right nostril and an oval mucous patch 2 x 4 cm. at the left angle of the mouth. Conjunctivae and sclerae were normal, and pupils were equal, regular and reacted normally. The mouth presented unusually bad oral hygiene with numerous dirty and some carious teeth, receding gums and very odorous breath. The neck showed some palpable anterior cervical glands. No abnormalities were noted in the chest, heart and lungs, clinically or on routine flat chest plate. Blood pressure was 120/65. No palpable masses were found in the abdomen; anus and rectum were essentially negative. Inguinal glands were only slightly palpable bilaterally, and no abnormalities in reflexes were noted. Genitalia were negative except for the superficial, slightly indurated, crusted lesion mentioned on the shaft of the penis. Darkfield examination from mucous lesion in the mouth showed typical *Spirochaeta pallida*, and all serologic tests for syphilis were positive.

Impression was (1) syphilis, early secondary, darkfield positive, sero-positive, (2) a recent (six months') dermatitis of undetermined cause, and (3) possible idiopathic epilepsy.

Treatment Course

June 23, 1941—First day therapy—After receiving 800 cc. of solution (0.096 gms. mapharsen) and while eating lunch, patient suddenly complained of nausea, became very pale and lost consciousness, at the same time throwing himself backwards, thrashing the arms and legs, groaning and vomiting during the attack which lasted 1½ to 2 minutes. He then regained consciousness and said he felt all right. The attack resembled a grand mal seizure. Patient was continued on treatment and the remainder of the 2000 cc. quantity of solution was completed without further reaction.

* Read in part by Captain Francis G. Sheehan, M.C., before the Indianapolis (Marion County) Medical Society, February 3, 1942.

† Director, Division of Venereal Disease Control, Indiana State Board of Health.

June 24, 1941—Second day therapy—No reaction, only complaint being slight vein ache, temperature 100° maximum, body surface lesions which had been accentuated on the first day were fading rapidly. The mouth and nose lesions appeared much less active and less prominent.

June 25, 1941—Third day therapy—Uneventful day. Maximum temperature 100°. Lesions continued to regress.

June 26, 1941—Fourth day therapy—Patient complained of slight frontal headache and general malaise, which subsided following completion of day's therapy. There was no evidence of drug intolerance. Maximum temperature 100°. Mouth and nose lesions were much improved.

June 27, 1941—Fifth day therapy—Severe vein ache; required morphine. There was evidence of a mild phlebitis proximal to insertion of needle. Had nausea and vomiting and complained of feeling weak. Treatment was completed (1200 mgms. mapharsen total).

Post-Treatment

June 28, 1941—Routine lumbar puncture was done. Fluid was clear and pressure normal. Patient was apprehensive; complained of frontal headache. Toward evening he became confused, was inattentive, and conversation was rambling. Neurological examination revealed no abnormalities, although he had a rather pronounced tremor of hands and mouth. At 10:15 p.m. he had a convulsion lasting about two minutes, followed by about twenty minutes of stupor, after which he roused, irrational and confused. Pupils were equal and contracted, but reacted to light. No paresis nor spasticity was noted. No abnormal reflexes were found except questionable hyperactive tendon reflexes. The picture was that of a toxic encephalitis.

June 29, 1941—From 10:15 p.m., 6-28-41, to 4:30 p.m. 6-29-41, patient had five convulsions. Between seizures he was very restless, semistuporous, and irrational. Blood pressure ranged around 140/85-90. He received 1 cc. of adrenalin about 8:30 a.m. and 1 gram of sodium thiosulfate at 8:00 a.m. and at 4:00 and 8:00 p.m. Sodium amytal 1.5 cc. was given intravenously, after which he became more quiet. Glucose proctoclysis was given.

The neurological consultation report follows: "The history was as given, except that the family denied patient had any fainting spells except at the sight of blood or pain. He had been a truck driver and had had no difficulties. The belief was that the likelihood of petit mal attacks or previous epileptiform seizures were eliminated. The history of the convulsive seizure of a grand mal type on the first day of his five-day treatment is noted, and the fact that he had completed his treatment without further trouble until over twenty-four hours post-treatment is noted. The neurologist described one of these seizures as a cry-tonic and clonic phase, with cyanosis, incontinence, et cetera. The perspiration was profuse, especially about the head. The patient attempted to assume meningitis posture

—lying on the side, knees drawn up, and neck slightly stiff. Pupils were sluggish to light but equal in size. E. O. M. normal. The right disk was flat. No paresis of arms or legs. No Hoffman, Babinski or Chaddock; abdominals absent, cremasterics present. Patient reacted to pin prick to deep pain, neurological impression was meningo-encephalitis."

June 30, 1941—8:00 a.m.—Patient was free from convulsions the past sixteen hours. Was awake, rational, and cooperative. Lumbar puncture was repeated, the fluid was clear, opening pressure was 150 mm. 10 cc. of fluid was withdrawn; the closing pressure was 80 mm. Sodium thiosulfate, 1 gm. intravenously, was repeated. Additional neurological consultation noted that there was no apparent paralysis, no stiffness of neck, or Kernig sign; reacted to deep and superficial and painful stimuli; no face or tongue palsy; ocular movements normal in range, although patient was not yet cooperative enough to determine full range, or if nystagmus was present. The neurological impression substantiated our own that we were dealing with an acute encephalopathy of arsenical origin, as the most likely diagnosis, although the complete recovery following the first convulsion was somewhat puzzling. No specific additional therapy was recommended.

July 1, 1941—Patient was definitely improved; had no more convulsions, rested well, and appetite was good. Neurologic examination revealed no abnormalities.

July 2, 1941—Lumbar puncture showed clear fluid under normal pressure. Patient was more alert, resting, and complained of only slight headache.

July 3, 1941—Continued improvement; no physical evidence of cerebral complications.

July 5, 1941—Lumbar puncture repeated; fluid clear, pressure normal. Patient was sitting up.

July 6, 1941—Lesions were markedly faded. Patient was up and about ward, was stronger and was discharged to the Out-patient Clinic.

July 11, 1941—Patient returned to clinic for physical and serological check-up.

During the period of treatment there were no urinalysis findings which were abnormal, and only a faint trace of urobilinogen on the first two days of intensive treatment. The blood examination was essentially negative except leukocyte count the last day of treatment and second day post-treatment of 11,550 and 12,750, respectively. There was a fall in blood platelet count from 230,000 to 120,000 between the beginning and completion of treatment. During the encephalopathy, globulin was 3+, total cell count 405, differential cell count 8, colloidal gold 4433332110, sugar 103, and Wassermann negative. On the third day post reaction, the colloidal gold curve was 5544333220. The arsenic concentration analysis was 0.048 mgms. percent per 100 cc. of blood. Post-treatment and reaction course has been satisfactory and uneventful.

Present

Two years later, the patient is clinically and serologically negative, blood and spinal fluids. His wife developed a seropositive syphilis subsequent to his, was treated on her specific request by five-day intensive method July 28 to August 1, 1941, and received 1200 mgms. of mapharsen plus 120 mgms. soluble bismuth cevitamate. She afterwards became pregnant and delivered a clinically, seronegative baby on 8-28-42, who has consistently remained negative as well as both parents.

Cumulative evidence in our hands has confirmed our opinion that different lots of arsenicals vary greatly in their toxicity, although chemical assay or reassay may show no difference whatever. Sedation in sufficient quantity to control convulsive seizures is, of course, necessary, but oversedation, particularly by barbituric acid derivatives is questionable in our opinion and possibly even contraindicated because of their increasing cerebral congestion where a cerebral edema is already a dangerous potent factor.

THE DIAGNOSIS OF ACUTE APPENDICITIS

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The diagnosis of acute appendicitis is fairly well understood by most of the medical profession, and an article dealing with this subject might be looked upon as being presumptuous. Yet, something must be amiss, for there continue to be far too many ruptured appendices, and it is thought by some that the incidence of this grave complication is actually on the increase. If this is the case, it might seem that the diagnostic methods now in use are not as good as those used formerly, or that some indifference towards this disease as a whole has developed among the profession. In this article we intend to deal primarily with the clinical diagnosis of the disease, and to say very little about the laboratory aspects.

Most of the older textbooks on surgery attach considerable significance to the history as a diagnostic aid in acute appendicitis, and state that the disease begins with cramp-like abdominal pain, usually epigastric in location, followed by nausea or vomiting with eventual localization of the pain in the right lower abdominal quadrant. It would seem that this rather exact description of the clinical behavior of acute appendicitis is well known, but its diagnostic significance is not appreciated, and in recent years has been accorded a decidedly secondary place to laboratory procedures in the diagnosis of this disease. In a comprehensive and excellent article on a large series of patients with acute appendicitis Slattery¹ states that "A review of individual case histories plainly demonstrates that little diagnostic reliance could be placed on the patients history, which in many instances was bizarre, to say the least, due to his etiological concept of the disease." It is our feeling that such is not the case, and that an accurate history is the most important single factor in the diagnosis. A

review of the etiological factors and the pathological physiology involved will serve to clarify this concept.

Clinical² and experimental evidence collected during the past few years seems to indicate that by far the most common cause of acute appendicitis is obstruction to the lumen of an appendix whose mucosa possesses the normal secretory power. This obstruction varies in degree and severity, and may be intraluminal in type such as that caused by a fecalith, or extraluminal such as that caused by adhesions, kinks, or torsion. Burgie³ has shown that if the lumen of the appendix is obstructed by a fecalith, for instance, the mucosa of the appendix will secrete fluid and cause that portion of the appendix distal to the point of obstruction to become tightly distended and tense. The mucosa becomes flattened out, bacterial invasion of the traumatized, partially devitalized mucosa then occurs, with suppuration and ulceration, and this process progresses to perforation of the appendix if the obstruction is complete or if it is not relieved. We are indebted to Wangensteen and his co-workers for promulgating this concept of the disease and for offering experimental evidence as to its proof. Appendicitis, then, in its early stages represents a type of closed loop bowel obstruction, which if complete enough leads to bacterial invasion, suppuration and the clinical picture presented by infection.

One can use this concept of the disease to explain and to interpret the history, clinical, and laboratory findings. Thus, when the lumen of a viscus is obstructed, it responds by trying to empty itself, and in the case of the appendix the pain produced

* From the Surgical Service of the Welborn Walker Hospital.

¹ Slattery, Louis R., and Hinton, J. William: Mortality Rate from Acute Appendicitis in a Municipal Hospital, *Am. J. Surg.*, **57**:294 (Aug.) 1942.

² Wangensteen, Owen H., and Dennis, Clarence: Experimental Proof of the Obstructive Origin of Appendicitis in Man. *Ann. Surg.*, **110**:629 (Oct.) 1939.

³ Burgie, Raymond E.; Dennis, Clarence; Varco, Richard L., and Wangensteen, Owen W.: Histology of Experimental Appendiceal Obstruction (Rabbit, Ape and Man). *Arch. Path.*, **30**:481 (Aug.) 1940.

is cramp-like or peristaltic in character, and may be primarily epigastric in location. At this time clinical examination reveals slight tenderness in the right lower quadrant, hyperperistalsis, a normal temperature and white cell count. As the disease progresses to bacterial invasion and suppuration, the cramp-like pains over the abdomen give way to a constant dull pain in the right abdominal quadrant, and examination reveals localized tenderness over the acutely inflamed appendix, hypoperistalsis, possibly fever, leukocytosis, and other signs of active infection. It should be noted that these are late signs and that they are the result of infection.

The same type of clinical picture is presented by closed-loop obstructions of the small bowel. At first there are violent generalized abdominal cramps associated with nausea and vomiting. At some indeterminate later interval there is localized tenderness, muscle spasm, abdominal distension, fever, tachycardia, leukocytosis, and shifts in the Schilling counts. This is the late, or more properly called the "neglected" stage of the disease, and it is important that one understand it as such. In other words, so-called "acute appendicitis" is not an inflammatory process, but rather a form of bowel obstruction which in its later stages is complicated by infection, and has its clinical picture dominated by the signs of acute inflammation.

Since March 21, 1941, the author has operated 320 patients for acute appendicitis. In this group there were 46 and 105 cases, respectively, with acute perforative and acute suppurative appendicitis, or a total of 151 cases labeled in the jargon of the operating room as "red hot" appendicitis. A careful history taken by the author at the time of admission revealed that in each instance there was a history of generalized cramp-like abdominal

pain followed at some variable interval by localization of the pain in the abdominal quadrant, where the appendix was later found at operation. The history was found to be the most accurate single element in the diagnosis of the disease. The location of the tenderness was located at the site of the appendix; the white cell count and temperature were variable, as would be expected since they depend to such a great extent on the stage of the disease process. The history was often difficult and exasperating to obtain, particularly if the disease was of several days' duration or if the patient was acutely ill. It was often beclouded by nonessential facts, such as what medicine had been taken, et cetera, but if one persisted he always obtained the picture of generalized cramp-like abdominal pain followed by localization of the pain and tenderness.

It would seem to us that there has been presented adequate experimental and clinical evidence as to the reasons why one would expect to see the type of history and clinical picture in acute appendicitis which has been stressed in this article. It would further seem that the art of history-taking is being neglected in favor of laboratory procedures, and that added emphasis needs to be given to the value of a so-called "typical history" in the diagnosis of acute appendicitis.

SUMMARY

The clinical diagnosis of acute appendicitis has been discussed, and the pathological physiology probably involved has been presented. In 151 cases of severe acute appendicitis the history of cramp-like generalized abdominal pain, followed by localization of the pain and tenderness, considered alone, was the most important element in the diagnosis.

ABSTRACT: FIND INFLUENZA VIRUS A IS ONE OF CAUSES OF PRESENT EPIDEMIC

Influenza virus type A is one of the causes of the present epidemic of respiratory disease, Jonas E. Salk, M.D., Wilbur J. Menke, M.D., and Thomas Francis Jr., M.D., Ann Arbor, Mich., report in *The Journal of the American Medical Association* for January 8. Their investigations showed, however, that a definite proportion of the illnesses involved in the outbreak they studied was not due to influenza A or B.

"Under the direction of the Influenza Commission of the Board for the Investigation and Control of Influenza and other Epidemic Diseases in the United States Army," the three men explain, "observation posts have been set up in various parts of the country for early detection of influenza in Army personnel.

"In the Virus Laboratory of the University of Michigan School of Public Health, such observations have been carried out for more than a year. On May 28, 1943, in the course of one of many routine surveys, several patients ill with influenza were seen at the Station Hospital, Fort Custer, Michigan. A strain of influenza virus, type A (Weiss), was isolated from the throat washings of 1 of these men, and in 2 other cases positive

serologic evidence of type A infection was obtained. Since no epidemic prevalence of influenza or other respiratory disease was noted at that time and the usual seasonal decline followed, it appeared that type A influenza virus could be the cause of sporadic disease.

"From the middle of October, 1943, the Army Specialized Training Program Unit at the University of Michigan was under constant detailed observation for respiratory disease. On Nov. 17 and 18, 1943, several cases resembling mild influenza appeared at sick call. On November 18 throat washings from 4 of these were inoculated intranasally into ferrets and mice. . . ."

The investigation showed that 2 of the patients had influenza virus type A, while the other 2, with clinically similar illnesses, failed to yield any evidence of the presence of influenza A or B.

"The present report," the three physicians say, "serves to detail the detection of influenza virus type A, at the onset of an epidemic in a Middle Western post before the disease was known to be present in other parts of the country."

CHRONIC FATIGUE

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SOUTH BEND

The problem of chronic fatigue is not one that is peculiar to our time nor to the additional efforts demanded of every one in wartime. In this connection it should be noted that published experience in both Germany and Great Britain indicates that ten hours a day is the maximum number which can be worked with efficiency. Prime Minister Churchill summarized this view in a speech to the House of Commons on July 24, 1941, when he said "If we are to win this war . . . it will be largely by staying power. For that purpose there must be one day in seven for rest, as a general rule, and there must be one week's holiday a year." Stimulation of a Dunkerque or Pearl Harbor may enable the worker to put in more hours temporarily, but inevitably increased accidents, sickness, poor work and the problem of absenteeism follow.

From the observations of chronic fatigue made prior to our war pressure, we may learn much about the adequate management of the problems. Kepler¹ notes that every year large numbers of patients seek medical assistance because they are chronically tired. He notes that examination usually fails to reveal anything significantly abnormal. The blood pressure may be slightly less than is considered normal, slight hypochromic anemia may be present, and not infrequently the basal metabolic rate is moderately depressed. On the whole, the results of the examination are disappointing to both physician and patient because nothing definite is found. It is also noted that the *cause* of chronic fatigue has been changed about once every decade. Autointoxication, imbalance of the autonomic nervous system, focal infection and endocrine dysfunction have all been, and to a large extent still are, considered as etiological factors. More recently avitaminosis and adrenal cortex insufficiency have come into vogue. Multiplicity of explanations is understandable because chronic fatigue is primarily a sensation and defies objective analysis.

Certain features of chronic fatigue appear to be of etiological importance in any study of fatigue. Moderate or even fairly severe muscular activity is usually followed by a pleasant sensation (of accomplishment?), whereas chronic fatigue is definitely disagreeable and does not bear relationship to expenditure of any form of energy that is measurable. It is interesting to note that it is worse in the morning and less noticeable toward evening. These patients usually say that they feel more fatigued in the morning, even after a good night's sleep. Many will add that they are surprised at feeling better if they don't sleep too well. They

are often relieved by expenditure of energy in the form of physical exertion, but ultimately become so incapacitated that the least effort becomes a burden. Then, of course, may be noted actual muscle inefficiency due to inactivity and loss of training. Critical situations demanding reaction usually are followed by these patients displaying a remarkable amount of energy, only to relapse again after the crisis passes.

Kepler believes that the above features suggest that the entire symptom complex is psychologic rather than anatomic or metabolic, and suggests that it be so regarded. This viewpoint has been held by psychiatrists for some time. Muncie² states that fatigue normally comes after effort and toward evening for day workers. "Tiredness" in anticipation of a task or at its inception should be suspected as a metaphorical use of the word expressing an unpleasant tone, confusing diffuse tiredness with a "tired of it" feeling. Schilder³ noted that weakness expresses the attitude that muscular effort is useless or impossible, and that the individual is giving up or being forced to give up in his efforts to be superior. It is a sign that he is not able to handle any of his problems. While admitting that weakness is paramount in every severe organic disease, it is pointed out that it is also an expression of any neurotic disturbance in which the individual feels he is no longer able to exert his power or that he is morally no longer entitled to do so. Fatigue is psychologically very closely allied to weakness, and in functional cases indicates that the individual no longer feels equal to his tasks. He confesses in this way that his aims are not worth while and that he should resign.

Many authors suggest the role that imbalance of life's activities and emotional factors play not only in fatigue, but in the neuroses and even in the psychoses themselves. Kepler⁴ borrows Richard Cabot's diagram in the shape of a cross, the four arms being named: Work which should not be monotonous drudgery, but should satisfy the urge of workmanship and the fruit of labor should be tangible and obvious; play should be relaxation and not dissipation; love implies a happy married life, a home and children and worship, the sincere devotion to something that is bigger than oneself. In the ideal life the four arms of the cross are equally divided.

Muncie² refers to the balance necessary between

² Muncie, W.: *Psychobiology and Psychiatry*, C. V. Mosby Co., St. Louis, 1939.

³ Schilder, P.: *Psychotherapy*, W. W. Norton Co., New York, 1938.

⁴ Editorial: *Fatigue and Working Conditions*, *J.A.M.A.*, 120:698 (October 31) 1942.

¹ Kepler, E. J.: *Chronic Fatigue*, *Proceedings of the Staff Meetings of the Mayo Clinics*, 17:340, 1942.

required and spontaneous efforts and feels that there must be a balance between work and rest, play and recreation.

Weiss and English⁵ come closer to explaining the necessity of a balanced life, as a matter of therapy, when they state that fatigue is very often due to emotional conflict which uses up so much energy that very little is left for other purposes.

Rest and vacation are the first thing that a physician thinks of in dealing with illness of emotional origin. Probably he recognizes that symptoms are due to external pressures of work or family life which induce emotional conflicts. He thinks first of reducing the pressures. It is felt, and rightly so, that in many instances rest will have a salutary effect. To be given permission by an authority, such as a physician, to give up one's duties and go to bed does much to reduce and remove symptoms. At about the turn of the century, S. Weir Mitchell achieved fame by prescribing the "rest cure." It worked very successfully because it catered to some of the most basic needs of individuals, particularly psychoneurotics. The patient was removed from the struggle of life and was nursed, massaged, pampered and well fed. In short, he was treated as an infant and all the infantile longings called forth were satisfied. Symptoms do disappear, and in many instances improvement is noted for some time. In many patients frequent repetition of this rest cure is necessary. Unfortunately, a great number of patients become invalids for life, with little improvement of their character by treatment providing so much secondary gain. Rest has its value in improving symptoms but does nothing to make the patient understand himself. This is particularly so when the matter of hypochromic anemia, decreased blood pressure and/or metabolic rate, auto-intoxication, focal infection, endocrine dysfunction, avitaminosis and adrenal cortical insufficiency are thought to be the cause of their difficulties, and the patient is warned to "take it easy." Rest does not show him what has made him ill nor does it cure his emotional conflicts. Rest cures and the "take it easy" advice actually are harmful to many people, particularly to the psychoneurotics, a great many of whom have to be not only told but pushed to carry on in spite of their symptoms. This decision should be dependent upon complete personality

studies if one will avoid the responsibility of making chronic invalids out of many people.

It is your author's opinion that few outside of the psychiatric field recognize that the unconscious urge to regress from the responsibilities of an adult life are in constant operation. We see this normally in the successful business man who purchases the farm on which he was raised (or symbolically another one) and does the things he day-dreamed of as a child. Actually, during his week ends or vacation periods he regresses to the happiest period of his life—his childhood—when he was cared for by his parents and was relatively free of responsibilities. There are many other so-called "normal" regressions. Sleep is probably to a degree regressive. Physical illness furnishes many opportunities to regress from one's responsibilities as an adult, and when continued rest as a result of physical illness is encouraged, the physician helps the individual to develop and further fix regressive phenomena, thus increasing the possibility of delayed recovery, chronic invalidism and chronic fatigue.

In the newborn all of one's energy is tied up in getting a full stomach. Later some of it is diluted away from this oral activity as bowel and bladder habits are established. This is still further diluted as the child comes in contact with other children, teachers, et cetera. Eventually, if progress has been satisfactory, because he is biologically mature he externalizes much of his energy in contact with everyday work activities, recreation, the church and the opposite sex. He is then a mature adult and very little energy beyond that necessary for good function is left within himself. If externalization of energy is adequate, there is no excess left within him to overload his points of emotional conflict and to shuttle back and forth within him and thus cause fatigue as it endeavors to express itself.

Balancing of activities is an absolute necessity if we are to properly externalize an adequate amount of energy to cut down on fatigue, chronic invalidism, neuroses, and psychoses brought about by accentuating the rest cure and minor physical manifestations.

Summary

A brief review of some of the viewpoints of etiological factors of fatigue is presented. An attempt is made to present the dynamic aspect of not only chronic nervous fatigue but of many so-called "neurotic entities" and a regime for their prevention and handling is suggested.

⁵ Weiss, E., and English, O. S.: *Psychosomatic Medicine*, W. B. Saunders Co., Philadelphia, 1943.

IF YOU HAVE NOT PAID YOUR 1944 DUES,
YOU ARE DELINQUENT

NEUROSES INCIDENT TO WAR STRAIN—THEIR EFFECT ON THE CIVILIAN POPULATION*

LARUE D. CARTER, M.D.

INDIANAPOLIS

In wars of the past little has been said or written concerning the hardships and vicissitudes met and endured by the civilian population. These things were taken for granted. It was understood that those in the home country must sacrifice for men in the fighting forces. Little has been said or written as to the effect of war on the mental health of those in civil life. No doubt wars from the beginning of time have taken their toll in precipitating mental ills among those in the home country, although medical history has dealt almost exclusively with war's effect on the military forces.

The psychological reactions of the present conflict on the civilian population is entirely different from any war of the past; present-day methods of communication, visualization and transportation bring the terrible actualities of this war acutely to our senses even though it is being fought thousands of miles away. There was never a war in which the man at home was so thoroughly aware that his efforts were necessary for the successful termination of a world-wide strife. A war of such magnitude is reflected in business, finances, industry, and in fact in every vocation and profession, great or small. There is hardly a man or woman who is not in some way emotionally or physically disturbed in these turbulent days of global warfare. It seems reasonable to suppose that under the stress and strain, anxiety and hardship of this war there would be a marked increase of psychiatric ailments affecting those in civil life; and also under the circumstances of the present war, a higher percentage of the civilian population will be directly or indirectly psychiatrically disturbed than in any other war of the past.

The psychiatric reactions of an individual are ordinarily based on his fundamental make-up. It is generally understood that the individual who succumbs to a psychotic or neuropsychotic disturbance is one of a low emotional or imaginative threshold. At the same time, no one has ever defined the normal threshold level of the emotions or imaginations. No one has ever been able to show that this threshold is ever so high that it can not be surmounted by the proper stimulus. In other words, any individual, no matter of what intellectual attainment or apparent emotional poise, may be mentally submerged by an overwhelming psychic conflict. Again certain factors, physical or physiological, may so lower the threshold of emotionalism and imagination that the individual responds adversely to comparatively mild stimuli.

This was brought out most forcibly in a recent paper presented by Commander E. Rogers Smith, of the Medical Corps of the United States Navy, in which he described profound neuropsychiatric disturbance occurring in officers and men of the highest intellectual and emotional types, but who, worn by disease, inanition, dehydration, and extreme physical exhaustion, broke under the hardships of warfare because their emotional and imaginative thresholds were lowered through purely physical and physiological factors. So, in the study of the various psychoses and psychoneuroses, bodily ailments, physiological, metabolic and chemical disturbances must be considered along with the fundamental psychiatric make-up of the individual.

In the past year and a half over three hundred psychotic and psychoneurotic cases have been seen in which there was some direct or indirect connection with the war effort. This does not imply that the stress of war was entirely responsible for these conditions. Many of them occurred in individuals who were fundamentally inadequate and who were merely waiting for some stimulus to arouse their psychiatric unrest; others would, no doubt, have developed their mental illness idiopathically or from some other psychic conflict, while a certain number would, in all probability, have lived a life of normal mentality.

To classify this group of cases, the majority belonged to the anxiety and mild paranoid states, some were primarily schizophrenics of the simple or catatonic types, some were reactive or conversion hysterics, a few were primarily cyclothymics, and others of poorly defined psychotic states. Considering first the anxiety group, these cases were usually seen in men and women at about the involutional and early arteriosclerotic periods, a time in life when the individual is most vulnerable to psychic shock or trauma. Many of the cases in this group gave an entirely negative psychiatric history; others had been regarded as emotionally unstable. The majority of women seen in this group were the mothers of soldiers or prospective draftees, women about the climacteric age. They had listened to radio programs, read the papers and pictorial magazines, seen the vivid reality of war on the movie screen, and in these dramatic presentations had visualized their sons. They became anxious and apprehensive, depressed and emotional, disinterested in their usual activities, and largely dominated by their morbid ideas. To this anxiety state in many instances were added the profound symptoms of an involutional psychosis, with feelings of inadequacy, remorsefulness, regrets, sin, guilt, and self-criticism. Other women of the same

* Presented before the Section on Medicine of the Indiana State Medical Association at Indianapolis, September 29, 1943.

age bracket but who perhaps had no near relatives in the military service, became concerned over the family business, financial security, the horrors of war, and the general social unrest of the country, to such an extent that pathological anxiety was the inevitable result. Younger women seem to have been less affected by the war activities; a few cases of conversion hysteria, fatigue neuroses and mild anxiety states, evidently precipitated by war stress, were observed. The majority of these younger women, however, were fundamentally unstable.

Men of the involutinal and early arteriosclerotic period are naturally exposed to the same emotional strain as are women of the same age. Many had sons or other relatives in the armed forces, with attending anxiety and apprehension, but to this was added factors indirectly associated with the war effort. Some of these men had practically retired from business or professional life, but because of patriotic or other reasons had found themselves again in the midst of civilian activities, with longer hours, greater responsibilities and administrative problems than they had ever experienced before. Other men were anxious and apprehensive over their financial security. They drew lurid and imaginative pictures of governmental collapse. They saw nothing in the future but poverty and pauperism. Still others had been necessarily dislocated from their usual business affairs. Some of those men were farmers, but on account of labor shortage and inability to secure proper equipment had abandoned their farms and gone into factories or other jobs for which they were untrained and unfitted. Some were small business men unable to secure supplies or efficient help, and consequently forced to close their shops and seek other employment. It is easy to understand how a man of this group, ordinarily prosperous and independent, finds himself in an entirely new environment; his pride is hurt, his self-esteem is lowered, he is discouraged and feels that life has little in store for him. A small but interesting group were men who had served in other wars and were anxious to again be in the military service, but on account of age or some physical disability were denied this privilege and, as a result, felt discriminated against. They were envious of more fortunate comrades, becoming depressed and morose, found it difficult or even impossible to abandon their hopes and desires for military activity and adjust themselves to useful civilian vocations.

The types of cases thus far considered have occurred largely in the involutinal period of life and often associated with early cardiovascular changes or other constitutional diseases. Such physical and physiological ailments have produced a background which renders an individual an easy psychiatric victim for such emotional conflicts as are experienced under war conditions.

The next group which we consider the most important is the paranoid state occurring principally in young men of military age. These cases varied in severity. Some were mild with vague suspicions,

ideas of reference and poorly-formed delusions of persecution. Others showed a profound disturbance in the imaginative field with hallucinations of hearing, fixed and well organized delusions of persecution and grandeur, even to the point of transformation of personality. A number of these cases occurred in industrial plant workers. They were impressed with the surveillance under which they worked; they became suspicious of their fellow workmen, thought they were being constantly watched and observed by guards and detectives; that they were being followed on the streets; that dictaphones and other devices for recording their speech and thoughts were planted in the shops and their homes, thus going through the whole gamut of suspicions, ideas of reference, hallucinations and imaginative notions. Paranoid states were observed in a small group of men who for various reasons were unable to enter the military service. They became suspicious of their friends and associates; thought they were being ridiculed and shamed, and felt that they were being accused of disloyalty or even cowardice. They became evasive and seclusive, gradually elaborating an extensive delusional system. These paranoid states, we believe, have occurred in men who were fundamentally unstable, belonging to the dementia praecox group, men whose emotional and imaginative thresholds were so low that they readily succumbed to a minor or insignificant stimulus.

In this war Army Examining Boards have been extremely careful in eliminating Selective Service men who are psychiatrically or emotionally unfit. Many of these rejected men are highly delighted and well pleased with their neurotic disability; it is an escape from military service. Others have an entirely different reaction to being rejected. Some of them drift into paranoid states, such as mentioned above; others, having been told they were psychiatrically unfit for military service, become anxious and concerned over their condition and develop hypochondriacal ideas, becoming obsessed with the notion that they are suffering from some serious mental ailment. They are introspective, self-analytic and interested only in their miserable feelings, often terminating as profound fear neurotics. A few cases of defensive hysterical reactions were noted in men not yet inducted into the service, but who, unconsciously on their part, were seeking escape from an intolerable situation.

No mention has been made of the effect of fear, anxiety, apprehension and mental strain on the autonomic nervous system with its attending physical disabilities, such as thyroid disease, gastric ulcers, chronic colitis, hypertension, heart disease, and many other well-defined ailments. This phase of war stress constitutes a field for independent study.

It is not within the scope of this paper to discuss the various psychotic and psychoneurotic disabilities seen in men who have been separated from the service on Certificate of Disability. Up to this time the majority of these cases have belonged to the

dementia praecox and constitutional psychopathic groups. Naturally, such cases would be eliminated early. However, as the war progresses we can expect the great mass of psychiatric disabilities among discharged officers and men to be defensive and reactive psychoneuroses.

With these brief observations one believes the civilian psychiatric burden in these war days has fallen largely on men and women of middle age but has often brought into activity latent mental disturbances in younger people.

The question arises: Is there anything which can be done or said to reduce the number of psychiatric casualties in these troublesome days? As the war goes on people will gradually become inured to its horrors and hardships; they will become accustomed to being separated from near friends and relatives; they will adjust themselves to a new and different way of living. The abruptness of the war activities is over; there is more time for serious consideration and appraisal of the situation; compensatory hatred and anger will replace submissive fear and anxiety; they will become more or less fatalistic, learning to live with their sorrow and disappointments. So, it would seem that from now on we can hope for a diminution of these psychiatric disturbances in the civilian population.

Another question is asked: What has happened or what will happen to those unfortunates who have already experienced psychiatric disturbances? A certain number has been restored to a normal way of thinking, particularly those of the anxiety group, others have improved but are still mental invalids; while still others have been irreparably damaged and will go through life as psychiatric derelicts—Civilian War Casualties.

DISCUSSION

L. P. HARSHMAN, M.D., Fort Wayne: This reminds me of the quizzes we used to have at Indiana University, but I did not have much opportunity to ask Doctor Carter questions because he was in the service at the time, but as I remember our teaching at the University it was "not to forget that the patient had a body as well as a mind," and since I first started to practice psychiatry I have constantly kept that precept in mind and regularly for the past fifteen years have reviewed the physiology of the human body. It is a thing I recommend to all of you. Furthermore, I want to mention the autonomic nervous system, which Doctor Carter says does not appear in his paper, but I think it is impossible to present a paper on the subject of neuroses without the autonomic nervous system having a part in it.

The greatest benefit I have in the practice of medicine is the knowledge I gain from my patients, and that is one advantage of country practice—what one learns about the patient and his family. That is where the general practitioner has the advantage; he practices where these things begin.

The general practitioner is the one who has the sympathetic approach, and when the patient comes

to us we have to find out whether the physical symptoms may have a psychologic origin.

Another point which comes to me is that my practice is in an industrial center and also somewhat of an agricultural center, and there is the question of security. I started my private practice in psychiatry during the depression, and at that time I was seeing the effects of *not enough money*; now we are seeing the effects of *too much money*. We see that in the younger groups, particularly the children. Just as I do not believe that psychiatry is a highly specialized branch of medicine, I do not believe that there are super-specialized men in child psychiatry, because when we study neurology and look back on the child's life we can see the impression of things that have happened—cases where children have been grossly neglected today because the mothers want to work—a child who should be staying with his mother, but she wants to go away to work.

It has been interesting to me to review the literature, particularly in the *Lancet*, with reference to some of the psychological manifestations in London and the larger cities of England.* In 1938 some of the psychiatrists pointed out some of the dire things that could happen, psychologically, to the population. However, time passed on and the things did not happen that the psychiatrists anticipated. It was found that the greatest preventive agency was the fact that these individuals became so busy taking care of other people who were physically ill that they forgot themselves. I wonder what is going to happen when the emergency is over. I cannot think it will be that in the future. However, let us not forget, as the doctor pointed out in his conclusion, that some of the psychologic principles are what Hitler has used in order to make the Nazis what they are today. Depression and economic strain are fatal for man or nation, and I am fearful we are on the same road now if we do not put our shoulders to the wheel and point out some of the pitfalls which threaten us. Certainly our work will have to begin with those of the younger groups—the boys who were rejected at the induction centers. I think that they deserve more time than they are getting now. We should discuss with them the reasons for their rejection and point out something they can do.

We should have a full discussion of this paper, for it is a subject in which there is neither beginning nor end.

MORRIS BALLA, M.D., South Bend: I would like to ask Doctor Carter whether he has observed young boys, in industrial factories especially—boys who have never worked in a factory before and who do not have time for recreation—whether they are apt to develop psychic neuroses?

I am glad Doctor Harshman mentioned the young psychoneurotics who are rejected in the Army, and who cannot understand what it means. They have anxiety neuroses because they want to get into the Army, and they are coming to us

with all kinds of psychic symptoms. And then we have the young women coming to our offices who have anxiety neuroses because they have just been married and separated from their husbands. It is a big problem.

DOCTOR CARTER, closing: The doctor asked if I have observed in my work those who are on the "graveyard" shift. I cannot say that that has attracted my attention, but I can easily understand how a young man who needs sleep at regular hours and who needs recreation at regular hours, when he loses his normal periods of sleep and recreation, that sort of thing might enter into his makeup.

Doctor Harshman reminded me of an experience I had a few years ago, when he pointed out that the family doctor is the best psychiatrist in the world. He knows his patients and how to handle them. I recall being called to a country town, a few years ago, to see a farmer's wife who lived some distance out. The family physician met me at the train and we drove out to the house. He was a man sixty-five years of age, and as we drove along I asked, "What seems to be wrong with your patient?" He said, "Well, principally the fact that she is Eliza Smith's grand-daughter." He made the diagnosis, and with that statement I could make a prognosis.

ABSTRACT: LEARN TROPICAL AND SUBTROPICAL DISEASE. CIVILIAN DOCTORS TOLD

American civilian physicians are advised by the Subcommittee on Tropical Diseases of the National Research Council to be familiar with the tropical and subtropical diseases that may be imported to this country by returning members of the military forces of the United States.

In a statement, approved by the Division of Medical Sciences of the National Research Council and the Surgeons General of the Army, Navy and Public Health Service and published in *The Journal of the American Medical Association* for December 18, the Subcommittee says:

"The military forces of the United States operating in tropical and subtropical areas are exposed to a number of diseases which occur only in those areas or are much more prevalent there than in this country. Some of these diseases will be brought back to this country in returning military personnel and may be seen by civilian practitioners of medicine either in persons infected abroad or in persons to whom the diseases have spread from the original cases. It is important that physicians be familiar with the diseases which may be imported, and that they be on the alert to diagnose and treat them correctly and to prevent their spread.

"Malaria is the most important of these diseases. In most tropical regions *Falciparum malaria*, the severe form of the disease, predominates. *Vivax malaria* is also common. *Malariae malaria* is relatively rare, and *ovale malaria* is very rare. Neither quinine nor atabrine prevents malarial infection. Suppressive treatment, formerly incorrectly termed 'drug prophylaxis,' will usually prevent clinical symptoms and keep infected persons on their feet as long as they continue such treatment, but many of them come down with clinical malaria within a few weeks after stopping treatment. Such cases are more likely to be caused by *Plasmodium vivax* than by *Plasmodium falciparum*. *Vivax malaria* is prone to relapse several times even after supposedly adequate courses of treatment. Some military and civilian personnel, returning to this country by air, become infected while stopping in highly-malarious areas en route. These persons have their first attack of malaria, usually *falciparum* infection, after arriving in this country. The symptoms may be obscure and the disease not suspected, and coma or even death may ensue before the diagnosis is made.

"Malaria should be suspected in every person returning from the tropics or subtropics. The disease may simulate almost any acute or chronic abdominal condition, upper respiratory or pulmonary conditions, meningitis, encephalitis, coma from other causes, or primary or secondary anemia. . . . Species identification should be made by a competent technician, and the disease should not be excluded until several blood examinations have been made at intervals of six to twelve hours. Vigorous

treatment must be instituted promptly to avoid fatalities and to diminish the incidence of relapses.

"Individuals without clinical malaria but in whose blood malarial parasites are found should be treated immediately or kept under careful observation.

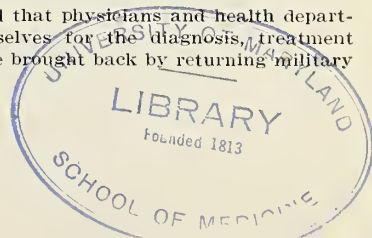
"Bacillary dysentery is usually an acute disease but may become chronic or give rise to carriers. Although the use of sulfonamide drugs will undoubtedly diminish the probability of chronic or carrier conditions, a history of the disease in military personnel should lead the physician to keep it in mind. The cause of chronic diarrhea or any vague abdominal symptoms should be investigated bacteriologically. Transient or chronic carriers of dysentery bacilli are usually present among the contacts of cases. . . .

"Amebic dysentery, or amebiasis, is much more likely than bacillary dysentery to become chronic or to recur in acute or subacute episodes. It may result in liver abscess even without previous noticeable symptoms. . . . The incubation period may be very long, or infections acquired in the tropics may produce no symptoms in the initial patient but may be responsible for family or community epidemics under conditions of bad sanitation or contamination of water supplies. Clinically amebiasis should be suspected in any person returned from the tropics who complains of blood in the stools, alternating diarrhea and constipation or vague abdominal symptoms. . . .

"Filariasis, caused by *Wuchereria bancrofti*, the lymphatic filarial worm of man, is prevalent in many parts of the tropics, particularly in certain islands of the Southwest Pacific. It is transmitted by a number of species of mosquitoes, the most important of which are probably *Culex quinquefasciatus* and *Culex pipiens*, the common night-biting mosquitoes of both hemispheres. The incubation period of the disease is usually six months or longer. . . . There is no specific treatment for the worm, but sulfonamides sometimes relieve the lymphangitis, at least temporarily. . . .

"The other diseases which may possibly be brought into the continental United States by returning military personnel are visceral and cutaneous leishmaniasis, schistosomiasis, the filarial worms *Loa loa* and *Onchocerca* [forms of filariasis], African trypanosomiasis, leprosy, relapsing fever and various fungous diseases of the skin. The probability that new endemic areas of any of these diseases will become established in the United States is very slight. They should, however, be recognized clinically and etiologically by the medical profession.

"It is recommended that physicians and health departments prepare themselves for the diagnosis, treatment and control of disease brought back by returning military personnel. . . ."



THE JOURNAL OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

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FEBRUARY, 1944

Editorials

THE MIDWINTER COUNCIL MEETING

The midwinter meeting of the Council was held in Indianapolis, January eighth, with a full attendance, every councilor being present as well as a full registration of Association officials. It was evident throughout the meeting that Council members and officials in general had in mind the epoch-making session of the House of Delegates, last November, when so many medical war problems were before that body. The Council did not forget that it had been mandated by that House to do certain jobs—and they were done and done well.

There may have been a time when Council membership was considered as a sort of empty honor—not too much to do, save to serve as the bellwether for the medical men of one's district; not so now. In these wartimes, when economic questions and problems affect every individual, it at times seems that medicine has more than her share.

The session was presided over by that strict parliamentarian, that man who believes in keeping things moving along, Chairman Romberger. True to form, the business of the day was dispatched with all the speed essential to a sane discussion of matters so vitally important.

As stated, the final roll call showed all members present, Dr. Portteus serving in the stead of

veteran member, "Cy" Clark, of the Seventh District. The minutes of the former meeting, having been printed in THE JOURNAL, were adopted.

The reports of the councilors, by districts, revealed that medical affairs in every section of the state were in good order, and that while attendance at meetings in some sections was below the normal, much of this was due to so many members being in the armed services.

The House of Delegates having ordered the Council to look into various financial phases of the state body, as well as take steps necessary to improve our Public Relations program, the Council buckled down to those jobs in short order.

Recognizing that additional help at headquarters was one of the crying present needs, an additional stenographer was authorized. Further, a raise in the salaries of the headquarters' force was unanimously voted. It was the sense of the Council that, with additional help in the office, Miss Kribs could take over many of the present duties of the executive secretary, allowing that official more time for attending public meetings here and there about the state, addressing many of these gatherings.

Plans for the 1944 session, Indianapolis, October 3, 4 and 5, were presented by Dr. Bert E. Ellis, who had been named as local arrangements chairman. Following the recent precedent, many of the entertainment features, such as golf and skeet, were eliminated from the program. The Stag Smoker, the annual dinner and the dinner for Women Physicians will be held as usual.

Council nominations for the Editorial Board were:

Charles N. Combs, Terre Haute

F. R. N. Carter, South Bend

Bert Ellis, Indianapolis

Lall G. Montgomery, Muncie

Dr. C. H. McCaskey was elected a member of the Executive Committee, and Dr. Cleon A. Nafe was re-elected. Dr. F. T. Romberger was re-elected as chairman of the Council.

Incoming President, Dr. J. T. Oliphant, addressed the Council briefly, commenting on some of the things to be done in 1944. He made it definitely clear that there was to be no retarding of our present progress and announced that one of the newer committees, of which he is a member, might expect to be called into decisive action at an early date.

The president also declared that the Public Relation program, which has been going along smoothly but too slow to suit him, would be speeded up, deeming this one of the most important phases of our current program.

Dr. Ellison, chairman of the Medical Relief Committee, also a member of the Advisory Committee to the Indiana Public Welfare Commission, spoke of some of the proposed plans along these lines.

Dr. Sensenich, of the Board of Trustees of the American Medical Association, presented a dis-

cussion of the "national picture," outlining some of the proposals in the offing.

We have been attending Council meetings in Indiana for several decades and have seen some mighty important matters go through the hopper, but the recent session was, to us, outstanding. There was, as was apparent in the last meeting of the House of Delegates, a singleness of purpose in the mind of every man present—that of meeting the various matters presented with calm, deliberative consideration. Due consideration should also be given to the presiding officer, Chairman Romberger, who held the assembly strictly to a discussion of the matter at hand and so expedited the agenda that the session closed an hour or more earlier than usual, yet due time was given every proposal that arose. The Indiana State Medical Association may well feel proud of its Council.

PRESIDENT OLIPHANT SPEAKS

The current number of *THE JOURNAL* devotes a page to the address of the incoming president, "Jake" Oliphant, which was given before the mid-winter session of the Council in January. For some forty years we have listened to our new presiding officers as they outlined the things they had in mind for the current year, but never before have we been so deeply impressed as on this occasion.

There was no oratory in this presentation; it was all straight business and every man present *knew* just what Jake was talking about and what he planned to do with many of our problems.

He agrees with us that the last session of the House of Delegates was the most interesting, the most momentous of the many that we have attended. He sensed the fact that the House was looking for action—and got it.

His comment on the Wagner-Murray-Dingell Bill is a classic and should be digested by every member of the profession. Only a keen, shrewd, analytical mind could have formulated such a presentation.

Like many other students of present-day medical economic questions, he feels that the parent body of organized medicine has "muffed" many a ball that has come its way. This criticism is not vitriolic in character; it is but the observations of a man who has all along been alert to the problems that were in the offing, and has taken plenty of time to think of possible solutions.

It is more than apparent that President Oliphant wants action and that committee assignments are made with that end in view, rather than with the desire to please personal friends and "home county" members. Several of our standing committees will work as they never have worked before—yet recently they have done a yeoman service. Jake Oliphant will hold the whip hand, and on occasion may find it advisable to use the lash a bit.

We commend his Council presentation, and urge every reader of *THE JOURNAL* to turn to this page, and as we have said, *digest* the whole context.

SOMETHING TO THINK ABOUT

What with a step-up in every activity at headquarters, together with the ever-increasing duties incident to the global war, we have come to the point where something will have to be done about it. As it now stands, our executive secretary literally has his hands full and should have someone take over many of the smaller details of his work.

Without hesitation, we state that the organization of the Indiana State Medical Association, as it now stands, is the outstanding medical organization in the country. There never has been a call made that Indiana has not been in the van in answering that call. It seems that we often have had a foresight that is almost uncanny, preparing for eventualities that had not yet come to pass but which finally occurred.

This, of course, means that many other states have watched us with great interest in many instances, wishing to know just how we do things. They often send representatives to our headquarters to see at first hand just how the machinery is operated. Others ask that our executive secretary come and talk to them about it. All this takes a lot of time, yet we are glad to be of such service.

Over on *THE JOURNAL* side, we have one small room for the two full-time employees. This room is so cluttered up by desks, files and what-not that when we have a visitor someone has to sit on a table while we talk. We must have additional space for *THE JOURNAL*. And we can use, *to very great advantage*, additional help in that department.

Miss Rokke has been with us long enough now to know her way about; she is invaluable, as are the two young ladies in the general office. But, her knowledge and ability can still be extended if certain petty details are taken off her hands. Getting out a magazine such as we publish is not a mere matter of assembling just so much material; after this reaches the office and passes through the Editorial Department, it must be properly placed in the magazine itself. Proofs must be read, authors must be contacted, and everyone connected with the various articles must be consulted ere the magazine finally goes to press.

JOURNAL advertising is virtually a department within itself. Not only do we have to solicit advertising, but the planning necessary to a proper arrangement of this material requires much time. Several of our advertisers furnish cuts, others mats, occasionally one sends us a colored insert—all of which have to be properly placed, some in accordance with the stipulation in their contract.

One of the problems that hitherto has given us much concern is the frequent changing of addresses

of our members, which problem has become greatly accentuated during the war period, many of our members making frequent changes in location. One thing of which we are mighty proud is the fact that THE JOURNAL reaches our members no matter where they may be located. Of course, there are some instances in which the magazine does not catch up with a member, but our record in this regard is quite satisfactory. Recently, at some expense, we have installed a new addressing system, making quite a saving in man hours in the matter of address changing.

The above is but a brief picture of some of the problems at headquarters; we are not complaining about them, merely presenting them as they actually exist. The budget committee may be able to make a few adjustments that will enable us to employ more help; we may find places in which we can cut corners, thus effecting some saving. However, we need a complete readjustment of the facilities at headquarters, and it would be well for the Executive Committee, the Council, and the House of Delegates to make a complete survey of the situation, with an eye to making such changes as will bring about a higher degree of efficiency and permit expansion.

There can be no doubt but that within the next year new and perhaps greater problems will confront us, and we must be all set to meet them. As we now view it, the two things most needed, "musts" one might term them, are additional help and additional office space.

TUBERCULOSIS IN INDIANA

The November number of the *Monthly Bulletin* of the Indiana State Board of Health is devoted to the discussion of the many phases of the tuberculosis problem, as found in the State of Indiana, and a most excellent number it is. Starting with the front cover, which presents, in graph form, a study of the interconnection between the sales of Christmas Seals and the decline in the number of tuberculous cases within the state, the *Bulletin* teems with interest for the physician who is concerned with the problem.

The death rate index for the year 1905 was about one hundred seventy-five, whereas that for 1943 was less than fifty. At the same time the sales of Christmas Seals have increased proportionately, the graph lines having a remarkable similarity.

It is our opinion that not only does the annual Christmas Seals campaign afford funds for the Tuberculosis Association, but each little seal in some manner better acquaints the purchaser thereof with the objectives of the Association. Folk are becoming tuberculosis-minded, and much of the credit for this is to be given to the Christmas Seals.

Murray A. Auerbach, executive secretary of the Indiana Tuberculosis Association, has the lead article, "Case Finding Made a Reality." In this report he speaks of the x-ray examinations now being made at the Army induction centers, where some 12,000,000 men will have been examined within the next few months. Several more million men will have been rejected for military service because of palpable defects, and many of these having made application for industrial employment will be given an x-ray examination by plant physicians.

Thus, there will be many millions of such chest x-ray examinations, and as a result thousands of hitherto unsuspected cases of tuberculosis will have been uncovered. A statistician for the National Tuberculosis Association has estimated that over 27,000 such cases will be found to be in immediate need of institutional care. Auerbach makes bold to estimate that there are more than 10,000 active cases within this state, a large percentage of whom have not as yet been diagnosed.

In forty counties of Indiana 1,272 cases of Indiana men thus rejected were followed up by local health authorities, 241 of this group being definitely diagnosed as having an active tuberculous infection, and proper treatment was instituted.

Dr. Holland Thompson, head of the newly-created Division of Tuberculosis Control, discusses what his department has before it, as well as some of the means by which they hope to operate. He, too, is of the opinion that Indiana *must* have additional facilities for the institutional care of tuberculous cases.

Major Glen Ward Lee, State Medical Officer, Selective Service System, has a factual, informative discussion of "Tuberculosis Found in Selectees for Military Service." He states that a chest picture is now made in every induction center examination. Paper films were first used in the Fifth Corps Area, and where there was a question of interpretation of the paper films regular 14x17 films were used in a succeeding examination. The lack of properly-trained radiologists slowed up this program for some time, but now it is operating smoothly and with dispatch.

He reports that present Army regulations provide for the acceptance of selectees, provided that they do not have more than five well-calcified hilar glands, homogeneous in appearance, and so long as no individual gland exceeds 1.5 cm. in the greatest diameter.

A recent innovation is the creation of a Board of Review, which is composed of two radiologists, two tuberculosis specialists, together with the Director of Tuberculosis Control for the State of Indiana. Major Lee points out that the lower two-thirds of Indiana is in the high tuberculosis area of the United States.

Dr. Fred B. Wishard, medical director for the Delco-Remy Company, discusses "Tuberculosis in Industry." He believes that much of the increase

in cases of tuberculosis found by examining present-day applicants for employment is the fact that today all sorts of men, in all conditions, are seeking employment. It seems that everyone wants to join in war materiel production.

Dr. Thurman B. Rice, editor, writes on "Tuberculosis In and After Wartime," commenting on the fact that what might be termed "Service Examinations" are bringing to light hundreds of cases that might not otherwise have been diagnosed until too late. He also stresses the educational value of these findings. Folk are becoming more and more "tuberculosis-minded." The newer method of using a 35 mm. film, later enlarging it, has been of distinct aid in that it materially reduces the expense of radiography.

The whole program resolves itself into this: there are in Indiana hundreds of cases of active tuberculosis that hitherto have not been diagnosed. These young men are being sent back to their home communities for proper treatment, and it is the job of Hoosier Medicine to supply that need. It seems likely that additional hospital beds will be needed for this purpose, which affords an additional problem.

It would thus seem that the anti-tuberculosis campaign is receiving a decided impetus, and it becomes our job to do our part in such a campaign.

THE 1944 ELECTION

Comes now the "jockeying for position" incident to the spring primaries, the state and national conventions, and the fall elections—days fraught with much moment for the medical profession. As we have long said, it is not ours to sit idly by until that November date when our ballots are to be cast. Our problem begins right now, our activities should be contemporary with those of the so-called "politicians." With discerning eye we should "catalogue" every man and woman who aspires to public office; their previous record, if any, should carefully be gone over.

The problem becomes an intricate one when we consider that it is not only national but that it exists in every state, in every county, and in every local community. First, we may begin right at home, where our own folk are beginning to hanker after a seat in the Indiana General Assembly; and candidates for township trustee, the official "overseers of the poor," the county commissioners, who all too often have some degree of authority in the control of county hospitals—these and many others are all potentially matters of the utmost concern to the medical profession.

Too long have we as professional men sat idle while the politicians have seen to it that their favorites are named on this or that ticket, only to learn, after they were officially elected, that

too many of them are not friendly to matters that have to do with public health.

It often has been stated, and this by astute politicians, that an organized medical profession could control most elections. This is true, for no other group is so strongly ingratiated into the confidence of the American people; no other group so frequently comes into intimate contact with these folk, usually right in their own homes. It is not necessary for a physician to be a politician in order to carry on this work; as a matter of fact, he is better equipped for this if he has no official connection with either of the parties.

We dare say that practically every physician is frequently asked by his patients, "What do you think . . .?"—referring to some political or economic question before the American people. And the same group of questions frequently is propounded to physicians concerning local candidates for office.

Even though the question is not directly asked, there are frequent opportunities to discuss local and even national politics with those whom you know so well. If one-half of the members of the medical profession would take time to explain the plight we presently are in—referring to the attempts to "take over" the practice of medicine—to their own patients, it would be but a matter of days until these folk would express themselves to the representatives in the national Congress in plain language, language that even a politician understands.

Again referring to the Wagner-Murray-Dingell Bill, we have a mighty ally in some of our Chambers of Commerce. Men in these organizations are astute; they are students of political economy, as it used to be called in their college days; they have the foresight and the insight that prompts them to seek out any Senegambian that may be lurking in the woodpile. This is evidenced by the recent publication of an enlightening brochure on the Wagner Bill by the Indiana organization. More recently some of the eastern Chambers of Commerce have come out with strong, even caustic, declarations concerning this iniquitous bill.

It appears that Senator Murray has had a change of heart since he addressed the Annual Secretaries' Conference in Indiana a few years ago. At that time he declared certain things which would indicate that he held no such notions as he apparently is harboring these days. In a recent press interview he made a strong attack on the American Medical Association, because of that organization's activities against his bill. He comes right out in the open in the matter, which pleases us very much. Now we know what he really thinks about it.

The reading public has opportunity to learn much of this Utopian legislative proposal since the press is beginning to show an active interest in the matter, but we medical men should not make it necessary for them to gain their informa-

tion through the press—rather, we should take the time to explain the matter to them.

Let's be a little more politically-minded; let's get into this thing right now, rather than wait until the November election. A little missionary work now will do more good than a great "hurrah" campaign in the last few weeks prior to the election.

Check your local, county and state candidates, and do a personal job of checking. As we have said, there are local problems in which we are most vitally interested, as well as in those of a national character. Members of the 1945 Indiana General Assembly are to be elected, come next Fall, and it is our job to see that avowed enemies of the medical profession are defeated in the primaries. Headquarters has the voting record of members of the Indiana Legislature for many years past, in all matters concerning public health, and this information will be made available to you through your local legislative committees.

Never in Indiana's medical history has it been so important that we get into this thing in a personal way. It may take some little time, but it is well worth while. *We can end this thing, permanently, if we but make a concerted fight!*

Editorial Notes

So far as Medicine is concerned, Post-War Public Enemy No. 1 promises to be malaria. Not the old-time "Hoosier three-day shakes," but various types of this infection indigenous to the tropics. With soldiers returning from every country and every clime, it is to be expected that many rare diseases, most of them new to American physicians, will show up. Much is being written on the subject of tropical malaria, and it behooves us to keep up with the subject.

Dr. Carl H. McCaskey was elected to the Executive Committee at the recent session of the Council, succeeding Dr. E. O. Asher who had been a member of this committee for some time. The reason for this change is due to the fact that Dr. Asher has been confined to his home for some months and has been unable to attend the monthly meetings of this body. It was deemed expedient to assure a full committee, especially at a time such as this when this committee is called upon to face a large number of problems affecting the profession. During his service, Dr. Asher proved an invaluable member of this group, and it is hoped that his recovery will be speeded and that later on we may again have the advantages accruing from his large knowledge of problems in medical economics.

The odds are better than ten to one that some members have neglected to pay their dues for 1944, if the old law of averages works out according to past experience. If you have not attended to this little matter, better get at it right now. Officially, you become delinquent after February 1st, which *might* bring about some uncomfortable situations. Anyway, we need the money, and an additional reason is that early payment eases the clerical load at headquarters.

Press reports indicate that the construction of the new penicillin plant, at Terre Haute, is going on apace and that the plant will be in operation by December first. The Commercial Solvents Corporation will be in charge of operations and soon will have their large force of research men engaged in further studies of this "wonder drug." It is stated that most of the building will be glass-lined so as to facilitate better aseptic conditions.

The *Ohio State Medical Journal* takes some of its members to task because of the marked increase in the number of liquor prescriptions being issued. It seems that Ohio has state-owned liquor stores and that since the shortage of supplies they have been cutting down on sales, however permitting sales on the prescriptions of physicians. The increase in this sort of traffic is said to have grown at an enormous rate, and the editor opines that probably *all* these prescriptions are not for folk really ill. Verily, some phase of the liquor problem seems always with us!

Inasmuch as the Secretaries' Conference was held so late in the month, it was not possible to include a report thereof in this issue, but it was a most significant meeting and might well be termed an epoch-making event. A detailed account will be published in the March number.

The December number of *THE JOURNAL*, Pearl Harbor anniversary number, and generally known as the "War Number," seems to have met with universal favor; copies were sent to medical organization officials throughout the country and their responses have indicated that they give unstinted approval to the project. We have had many complimentary letters concerning this number of our magazine. The general idea was, of course, worked out at headquarters, but the project was so vast that it required the full cooperation not only of the headquarters' staff and the official family of the Association, but that of many men connected with the various departments of the armed forces. No doubt we soon shall have the reactions of many of our members now in foreign service, since these men have kept well in touch with what goes on at headquarters.

The State of Indiana closes its year with a cash balance of \$31,000,000.00 in its treasury, according to a report from the state auditor, Richard T. James. This is an increase in cash balance of something like six million dollars. Of course, there will be added expenses here and there, notably in the distribution of funds to school cities and other state agencies, but at that a cash balance of such proportions will make many less provident states envious. Again do we take much pleasure in the fact that Indiana has no bonded indebtedness—we pay as we go, and pay in cash.

Captain Sprague Gardiner, head of the neuropsychiatric clinic at Billings Hospital, Fort Benjamin Harrison, in an address before the Indianapolis Bar Association, declared that some 80 percent of shock cases, in actual warfare, are cured within a reasonably short time and the men returned to action. This is a marked improvement over similar conditions during World War I; all of us are familiar with the numerous "shell shock" victims, many of whom continued to be thus affected for long periods after the war, some of them never recovering.

Dr. Louis W. Spolyar, director of the Division of Industrial Hygiene, Indiana State Board of Health, reports a fatal case of acute cadmium poisoning in an Indiana plant. The exposure came during the flanging of a cadmium plated stainless steel pipe. The operation brought the flange joint to a cherry red heat, as well as a thick, blue smoke. Soon after the beginning of the operation the employees thereabouts complained of an irritation of the mucous membranes of the nose and throat. Two of the employees became violently ill and were removed to their homes. The chief symptoms at this time were vomiting, chest pains and shortness of breath. In one worker the chest pains increased in severity and he died within four days.

Daniel J. Tobin, wise old sage that he is, presently the head of the International Brotherhood of Teamsters, Warehousemen and Helpers of America, an A. F. of L. affiliate, gives this advice to his union groups throughout the country:

"No local union should have an expense greater than its income. During the war, local unions should save a substantial amount of their income each month to meet the days of distress which are sure to come. We have found local unions of less than six hundred or seven hundred members with two or three salaried officers who draw what we believe are unreasonable salaries, when you base the salary on the revenue of the local union. Unions are not created, nor do they exist, for the purpose of benefitting the officers of the union."

We have received a very complimentary letter from Mrs. Joseph S. Skobba—Colonel Skobba is now the head of the Psychiatric Department of Lawton General Hospital, Atlanta, Georgia—concerning the War Number of *THE JOURNAL*. Mrs. Skobba, nee Hope Toman, was for many years assistant editor of our magazine. She unhesitatingly pronounces the "Pearl Harbor Number" as being more than "tops"—says it is the *best ever*. "Miss Toman," as she is known to most members of the Association, was engaged in medical journalism over a long period of years, and in that time has looked over practically every journal published, hence, her complimentary remarks are doubly appreciated.

The late Clarence P. Wolfe, publisher of the *New Harmony Times*, conducted a reminiscent column in his weekly paper, talking about old times and customs in Posey County. We came across his item on "Old Christmas," which may be of interest to some of our older members. We dimly recall some discussion of these legends in our younger days, back in *Old Wild Cat*.

"'Wednesday night was Old Christmas, twelve days after the day usually observed. According to the old belief yet held by many Posey County folk of the old school, on the stroke of twelve Wednesday night the cows will drop to their knees and blow through their nostrils; chickens on the roost will turn around and the cocks will crow; the buds of the elder and blackberry bush will swell and turn green. The younger generation scoffs at this belief but there are many in Posey County who maintain that the cow prays and the other things enumerated come to pass on Old Christmas.'"

We of Indiana are indeed fortunate in the matter of assistance in the work carried on at headquarters—and be it remembered that these operations are carried on in quarters far too small for the highest efficiency. Literally, on many occasions we stumble over one another when we all get going at the same moment. We must have additional space, for one thing. In Miss Kribs and Miss Reid we have two assistants who know practically every detail of medical organization. Miss Kribs, officially known as the assistant executive secretary, doubles for the "Blonde Senator" on many occasions, and does a good job of it. Her services could be rendered still more valuable if but a few of the petty details of the office could be taken over by someone else. Miss Reid can, offhand, get for you the record of most anyone you wish, her knowledge of the files being of the uncanny type. And, in passing, we must have additional filing space. Miss Reid has charge of the membership records and can, at a moment's notice, dig up information on that score about any of our several thousand members. As in the case of Miss Kribs, some additional office help would markedly increase the value of the vast fund of knowledge concerning medical affairs possessed by Miss Reid.

So the Apothecary Table is to be discarded! Thus comes the announcement from the American Medical Association. No longer can we old-timers think and write in terms of grains, drachms and ounces; we must use the metric system. The latter is, of course, much more simple, *if one has been taught to think and write that way*, but some of us have used the Apothecary Table for so many decades that our minds simply will refuse to change over. Hence, it is more than probable that the modern druggist will have prescriptions coming into his store written in the "old style."

A northern Indiana paper wastes more than a column of valuable newsprint in setting forth a pro and con discussion of the merits of one of the habits of the present time, that of girls going without stockings and of men going without hats. While we recognize that our comment on the subject is quite useless and that it smacks of a Mid-Victorian idea, yet we feel like expressing an opinion, this to the effect that, first, comments to the contrary of these notions are of no use whatever. If a man thinks it "smart" to go about in near-zero weather without a head covering, and if a young woman wishes to bare her nether extremities to like temperatures, that is their affair and we can do little about it. It is quite like an eye physician telling a youngish patient that he cannot agree that some of the freak plastic spectacles are proper eyewear, if the patient really wants something that will be of benefit to vision. Our experience is that once such notions get into the heads of these folk, we are wasting time in talking against such ideas.

According to press reports, a physician from a western state came into a southern Indiana city last summer, to become a member of the medical staff of a local defense industry. Later he entered into the private practice of medicine in that city, seemingly without having undergone the formality of procuring an Indiana license. The State Attorney General's office thereupon filed a restraining order, and a short time later the attorneys for the physician in question filed an agreement in the local Circuit Court to the effect that the physician in question would cease violating the Indiana statute and close his office. Too many evasions of this law have been taking place in Indiana, each of them no doubt based on the allegation that extra medical help is needed in the defense industries. Physicians who should know better take on "assistants" who are not regularly licensed in the state, some of them wholly unable to meet the requirements of the Medical Practice Act. We have checked some of these cases and find that while some help may be necessary, there are plenty of licensed physicians to fill these places.

Charles L. Chaffin, long-time columnist on the *New Harmony Times*, reminisces as follows:

"What has become of the old-time doctor who used to come up to the bed, and the first thing he would say, 'Stick out your tongue. My goodness, what a coating. You take these every two hours, and if they don't help I'll give you some that will. Just bilious, you'll be all right in a few days. Don't get out in the sun too much. Oh, about fifty cents, I guess.'"

While it is a little early to give a complete picture of the traffic fatalities during 1943, there is sufficient data available to draw some rather definite conclusions. For the first eleven months of that year Indiana had had a reduction of something like 34 per cent in traffic fatalities, over 1942, a record far better than the national average, where the decline was 21 per cent. It is estimated that the lowered mileage of automotive vehicles in Indiana amounted to about 20 per cent, most of which was, of course, due to gasoline restrictions. But the fact remains that we still have too many such fatalities, not only in Indiana but in the whole nation. Even with our road system improvements, our intersection warnings and all that, motorists, too many of them, continue to drive as though they had the whole road to themselves. And the old, old effort to try to mix alcohol with the gasoline continues to add to the mortality rate. Verily, our legislators, although they have been wrestling with the problem for many decades, still have a job on their hands.

We have tried to refrain from too much criticism of the various "alphabetical" agencies operating out of Washington, but a recent situation has come to our notice that arouses a certain degree of personal ire. We refer to the OPA action in the matter of what for years has been known as flat lake herring, now officially called salt lake herring. This is a salt fish which as long as we can remember had a large sale throughout this section of the country. A few weeks ago Lowell Nussbaum, columnist in the *Indianapolis Times*, commented on the trouble one of his friends had in locating this delicacy this year. We have had similar trouble, though in former years this fish has been available late in November. We finally contacted a nationally-known fishery, who advised that these fish were caught, processed and packed, as usual, but that the OPA had forbidden sale thereof until a price ceiling had been set. Two months have elapsed with no price ceiling, so these "kits" and small barrels of fish are sitting supinely in storage, waiting until such a time as some OPA official gets around to naming the price at which they can be sold. Meantime, we are daily delving into our scant supply of ham and bacon for a breakfast repast, when we might be saving points by eating salt lake herring. Nerts!



President's Page



The much discussed patient-doctor relation has always been a very simple and direct one. When a person desired the services of a doctor, he looked about and selected the one he thought best qualified to treat him, and either presented himself to the doctor or summoned the doctor to him. When the illness was over the patient paid the doctor whatever fee was charged. If it so happened that the patient was too poor to pay any fee, none was expected. The service was the same in either case.

References to the practice of medicine in contemporary writings of every age indicate that this was the universal practice for more than two thousand years. It was the practice in the United States until well into the second decade of the present century.

The life of a doctor was incredibly hard and the remuneration was always poor; nevertheless, some of the brightest minds and some of the noblest characters have always been attracted to the profession. Those who can remember the older doctors from 1900 to 1910 know that they devoted themselves entirely to their patients. To them it was impossible to refuse to make a call regardless of the time of day or the state of the weather and regardless of the patient's ability or willingness to pay. To them a medical society was a place for a scientific discussion and improvement of their minds. They regarded any discussion of economic subjects as derogatory to their dignity and looked with disfavor on the promulgation of fee schedules. They believed that a doctor's fee was a matter to be settled between the doctor and the patient.

With this background and with this hoary tradition, the American medical profession was swirled into the vast and almost cataclysmic social and economic evolution that swept this country from 1915 to 1940. It is due to the honesty, sincerity and unwavering devotion to duty of our fathers that our profession was not swept away and replaced by some other form of practice long before now.

The doctors who emerged in 1940 are superior to their grandfathers of 1900 in skill and training. They are disillusioned about their debt to society. They regard themselves more as businessmen who have made a very heavy investment in time and money, and they believe that they are entitled to a fair return upon that investment. They are ruggedly individualistic and are inclined to believe that their fees are still a matter for them to settle with their patients.

They have made no concerted effort to make their services available to people with small incomes in any other manner than on the old doctor-patient relation. They regard this as a bed rock of free medical practice and without it they are sure there would be no incentive for self-improvement.

There has grown up a large segment of our population that is not concerned about this patient-doctor relation. These people would be satisfied with any doctor or any hospital that the government or some other agency would pay for. Then, too, there has been established in Washington a powerful and arrogant agency with ramifications in every state, which is known as the Federal Security Board. This agency is to have charge of the personally-conducted tour from the cradle to the grave when and if that utopian plan becomes effective. This board would be only too happy to take over the duty of purveying all hospital and medical care to all people now, and it is ready to thrust its foot into every door that is opened to it. It is very clear that if the medical profession is to survive, it must arrange its own house. It must be less individual. It must prepare to furnish a complete medical service that is within the financial reach of every patient who applies for it.



INDIANA DOCTORS CAN DO THE JOB*

J. T. OLIPHANT, M.D.

President of the Indiana State Medical Association

FARMERSBURG

I think the last meeting of the House of Delegates was one of the most interesting sessions of that body that I have ever attended. The delegates were all thoroughly interested and were looking for action. They passed a good many resolutions, seeking to translate their own quickened interest into some decisive movement, and they gave this body certain things to do which I am sure you will do. They also made a request that a special committee to study health insurance plans be appointed, and that this committee report back to this body at your next meeting with some recommendations. I have appointed such a committee and have used the best judgment I possess in selecting the personnel of that committee. I believe that it is the intention of the House of Delegates that this committee will meet and will come in here with some specific recommendations.

The House of Delegates also asked that some action be taken to defeat the Wagner-Murray-Dingell Bill, both now and for all time. We might be a little more dispassionate in our discussion of that bill if it were known as the Smith-Brown-Jones Bill. The connotation and the concatenation of the names Wagner-Murray-Dingell are jarring to the ear of anybody trained in the use of a stethoscope, but we must not lose sight of the fact that these gentlemen are trying to solve a problem that actually confronts the American people, a problem that has grown with industrialization and that is of vital importance to all of the people dependent on wages for a living. These people, ordinarily self-supporting, are, in time of unemployment, left entirely without means of support. Our times of prosperity come in cycles, and between these cycles there are times of depression and unemployment when wage earners are left without money. No one ever again wishes to see a situation like that which arose in 1932 and lasted until about 1938. Millions of our people could not obtain food, clothing or medical attention without appealing to the charity of the taxpayer, and during this period of depression billions of dollars of tax money were poured out to support these people.

These three gentlemen, Wagner, Murray, and Dingell, are trying to solve that problem. They are trying to solve it the politician's way. They have a solution for it. Under the terms of their bill, there will never be a time when an idle person cannot buy food, clothing, medical care and most

of the luxuries, whether or not he even wishes to have a job. But, the solution under this bill would strip the medical profession of its freedom and the doctor would become subject to the will of his ward politician.

Under this solution all of the people in America would be regimented into a vast national socialistic bureau with a dictator at its head.

Many sensible, straight-thinking people, seeing this problem, and with an honest desire to help with a solution, have been trying to get the cooperation of the medical profession in some plan that will tide the wage earner over the seasons of unemployment. They desire to do this in some manner that will preserve as much as possible of our present way of life and that will not make any part of the people subject to the will of a dictator. But, for some reason or other, the leaders of our national society have not seemed to be very cooperative. To this date, about their sole contribution has been a quick and decisive "No" to every plan offered. Now, I am not competent to judge whether our national body has been right about this. I cannot grasp all the implications of any plan or law that would meet the needs of the times. If our national body has declined to cooperate in an honest effort to solve this social problem, it is time that some state group or some independent group of physicians should make a study to determine whether or not the doctor should assist in framing a law that will meet the economic needs of the wage-earning part of our population.

You gentlemen seated here are the chosen leaders of the medical profession of Indiana. On former occasions, when confronted with problems, some of them of national scope, you have gone into a huddle and have come out with a solution that was the answer to the question. These solutions you have sometimes presented to the A.M.A. and they have been eagerly seized upon, and the A.M.A. has been gracious enough to designate them as the "Indiana Plan." Other state groups also have used and adopted your solutions to problems, and they, too, have given you the credit. If you men would go down into your bag of tricks again and come out with the answer to this, the greatest question that has confronted us as physicians in our lifetime, you will have rendered a service to the medical profession greater than any that has been rendered from the time of Hippocrates down to this present moment.

* Talk made at the regular midwinter meeting of the Council of the Indiana State Medical Association on January 9, 1944.

YOUR FEDERAL INCOME TAX

WILL H. SMITH

Collector of Internal Revenue, Treasury Department
INDIANAPOLIS

Taxpayers who file Federal returns on the calendar-year basis must do so on or before March 15, 1944. That return will be a settlement of the taxes for both the years 1942 and 1943 under the plan provided in the law for the transition to the pay-as-you-go or current tax payment system.

Physicians and other professional people must report their income on Form 1040. The net profit (or loss) is entered in Item 8 of the return Form 1040 and the entry must be supported by the information called for in Schedule C(2), or by another schedule particularly adapted to the business or profession.

In reporting income from a profession, all income so derived must be shown in the schedule. In arriving at net income or loss, the taxpayer may use the method of accounting regularly employed in keeping the books, so long as the method is reasonably consistent and clearly reflects the income.

Expenses deductible in arriving at net profit (or loss) from a profession (item 8 of return Form 1040) are the normal current costs of producing income. Such expenses must be distinguished from those incurred for the convenience, comfort, or economy of the individual pursuing the profession, or in the nature of loans, gifts, capital investments, and the like. The distinction lies in the purpose and nature of the payment, rather than in any account in which it is charged.

Business expenses may include salaries and wages paid (if not in contravention of the Wage and Salary Stabilization Act of October 2, 1942), interest on business indebtedness, taxes on business and business property, loss arising from business operation, bad debts arising from sales or services, depreciation, obsolescence or depletion and rents, repairs and other expenses. Other items includible are management expenses, commissions, labor, supplies, advertising or other selling expenses, and insurance premiums for one year.

In the case of a professional man, maintenance and repair expense of an automobile used for professional purposes (or that portion of the expenses applicable to professional use) is allowable, as well as membership in technical societies, subscriptions to technical journals and current magazines used in the reception room, costs of supplies, and fees paid to other professional men for professional assistance.

If a professional man uses his residence as office and home, he may deduct the expense applicable to that part used for professional purposes. Expenses not deductible include the cost of books and the cost of instruments and equipment having a useful life longer than a year (as these are regarded as capital items on which depreciation may be allowable), and membership dues in a purely social club.

Cost of incidental repairs is deductible provided the property account is not increased by such expenditures, but repairs in the nature of replacements, betterments, and improvements are regarded as capital expenditures and are not deductible.

After computing the tax on 1943 income, they will compare that tax with the 1942 tax. They will then enter on the return, in general, the greater tax plus an addition of one-fourth of the lesser tax as the total amount due, the balance of the lesser tax being forgiven. A substantial part, if not all of the tax, will already have been paid by most taxpayers, since they may take credit for all of the payments made on their 1942 income tax returns, together with the additional amounts paid through payments of estimated tax in September and December, 1943, and if, after taking these credits, a taxpayer owes a balance, he may postpone for one year (without interest) any amount of the unpaid balance up to one-half of the unforgiven portion of the lesser year's tax. The remainder of the unpaid balance, if any, will be due not later than March 15, 1944, while taxpayers who have paid more than the total amount due will be eligible for a refund or credit.

Payments of income taxes must be made to the office of the Collector of Internal Revenue where the return is required to be filed—that is, to the collector for the district in which is located the taxpayer's legal residence or principal place of business. If he has no legal residence or principal place of business in the United States, payment should be made to the collector at Baltimore, Maryland.

Payments of tax may be made in cash, or by check or money order payable to "Collector of Internal Revenue." If payment is made in cash, the taxpayer should request and the collector should furnish a receipt. If, however, payment is made by check or money order, the canceled check or the money order receipt is usually a sufficient receipt.

After a return has been filed, it is associated with the declaration of estimated tax, if any, filed for the same taxable year, and checked for accuracy by the Internal Revenue Service. The taxpayer may be subject to examination or inquiry relative to matters connected with the return, or his income, and he may be asked for further substantiation of statements made in the return. If the estimated tax reported in the declaration as payable directly to the collector of internal revenue was substantially understated, a penalty for understatement may have been incurred. Estimates could, however, be amended once in the last quarter of 1943 on or before the installment date, and only the final estimate for the year will determine whether a penalty is due.

Military News

Dr. Frederick K. Allen, of Fredericksburg, who is serving in the United States Medical Corps, has been promoted to a captain. Captain Allen is serving with a medical battalion of amphibious engineers in New Guinea.

Lieutenant Theodore D. Arlook, of Elkhart, has recently been given a promotion and is now Captain Arlook. He spent seven months in Australia with an Evacuation Hospital, and then was sent to New Guinea, which is his present location.

Dr. C. J. Aucreman, of Montpelier, captain in the Army Air Corps, who recently returned from the Hawaiian Islands, has left for Randolph Field, Texas, where he will enter the Aviation School of Medicine for training as a flight surgeon.

Word has been received from Lieutenant Nelson E. Boyd, of Freelandville, that he is in fine health and is now stationed in Chinese Burma.

Major Melvin S. Durkee, of Evansville, has been promoted to lieutenant colonel in the Army Medical Corps.

Dr. Lee J. Maris, of Attica, stationed with the medical corps of the United States Army at San Francisco, California, has been advanced from first lieutenant to captain.

J. R. Eastman, M.D., Jr., of Indianapolis, has been commissioned lieutenant (j.g.) in the Medical Corps of the United States Naval Reserve. Lieutenant Eastman had been a resident in surgery at the City Hospital for the last year.

Captain Walter A. Compton has been promoted to the rank of major, and appointed assistant director of the Medical Division Training School for Medical Technicians connected with Fitzsimmons General Hospital, Denver, Colorado.

Captain J. B. Berkebile, of Peru, who is now in the Army Medical Corps, was among nineteen soldiers and officers taken on a nine hundred fifty-mile cross-country trip as a special award for excellent work. The trip was made in a huge C-47 transport plane.

Lieutenant H. W. Eikenberry, of Peru, entered the Medical Corps over a year ago, and is now in Italy.

Word has been received that Lieutenant E. L. Fitzsimmons, of Evansville, has been promoted to captain. He is stationed at the Hobbs, New Mexico, Army air field.

The promotion of Lieutenant Colonel Guy A. Owsley, executive officer of Billings General Hospital, Fort Benjamin Harrison, to colonel has been announced.

Dr. Harrison C. Ragsdale, of Bedford, will report for duty on December twentieth as lieutenant commander at the United States Naval Hospital at Farragut, Idaho.

Dr. T. B. Lorenty, of Gary, has been promoted to the rank of captain in the Army Medical Corps in Italy. Captain Lorenty is a veteran of the African and Sicilian invasions.

Lieutenant (j.g.) Creig S. Hoyt, of Pittsburgh, has arrived in Crawfordsville to assume his duties as medical officer of the Navy V-12 Unit at Wabash College. Lieutenant Hoyt was graduated from the University of Pennsylvania School of Medicine.

Norman R. Booher, M.D., of Indianapolis, has been promoted to lieutenant colonel and is with the United States Army 40th General Hospital, where he is executive officer. He was graduated from the Command and General Staff School of Fort Leavenworth, Kansas, this past summer.

Colonel Franklin T. Hallam, who stated that he is "out in the wilds," reported that he reads and re-reads the MEDSOC letters many times—said that he enjoyed them all even though it takes a month or so to get them; thinks it's the best friendly-message idea that he has ever seen carried out.

The Hoosier Vagabond, Ernie Pyle, in his column reports that he and a wounded paratrooper captain met on an Italian mountainside. The captain was Francis G. Sheehan, of Indianapolis, who had been wounded while in action, according to a telegram from the War Department received in Indianapolis on December seventeenth. Mr. Pyle reports that Captain Sheehan's wounds were not serious.

The address of Captain Charles F. Seaman, of Indianapolis, is now 0-1684650, 330th Service Group, Tinker Field, Oklahoma.

Dr. J. R. Rohrer, of Washington, has been promoted from captain to major, it has been learned. Major Rohrer at present is serving in the American forces in the Italian theater of warfare.

Russell L. Malcolm, M.D., of Richmond, formerly a major in the Army Medical Corps, has been promoted to the rank of lieutenant colonel, and is chief of surgery at the 35th Evacuation Hospital, Camp Tyson, Tennessee.

NOTICE

Captain Robert B. Smallwood, of Bedford, who has been with the station hospital at Gulfport, Mississippi, was in our office recently. He suggested that groups of Indiana physicians who are medical officers, in the same camp or unit, might get together and appoint a correspondent for *The Journal of the Indiana State Medical Association*, whose duty it would be to send news items to *The Journal* in reference to the accomplishments of Indiana physicians in their area. We think this was a good suggestion, and we hope that it can be carried out. So get together and send us the name of your correspondent.

Lieutenant William S. Robertson, of Spiceland, is now with a United States Naval Hospital, c/o Fleet Post Office, San Francisco, California.

Lieutenant (j.g.) Wendell A. Prough, of Indianapolis, and Miss Nancy Lee Willits, of Corona, California, were united in marriage November twenty-seventh at the Saint Frances Chapel, in Mission Inn, Corona, California. Lieutenant Prough is a graduate of the Indiana University School of Medicine, Indianapolis. He is now stationed at the United States Naval Hospital at Corona.

Lieutenant H. M. Pickard, of Elkhart, after five weeks' training was sent to England where he remained until the invasion of North Africa. Then he was sent to the African continent, arriving there three days after the initial invasion. After two months at Oran, his outfit proceeded east and south along the Mediterranean through Algiers, Constantine, Tebessa and on into Tunisia, where they saw most of the activity in which the Americans were involved. Dr. Pickard suffered from a bite by a poisonous spider, necessitating hospitalization, and he sacrificed twenty pounds of weight. At the present time he is in Sicily.

Captain B. J. Smith, of Kingman, is a flight surgeon in a "marauder" group.

Major James V. White, of Terre Haute, has been promoted to lieutenant colonel, and is now assigned to the 67th Medical Regiment at Camp Barkeley, Texas.

Captain Eugene C. Murphy, of South Bend, has been promoted to a major in the Army Medical Corps, according to a War Department announcement.

Of three thousand one hundred fifty-six deaths of physicians reported in *The Journal of the American Medical Association* during 1943, twenty of the doctors were killed in war action and one hundred five died in military service.

We have been informed that the new year brought a promotion to Clifford C. Taylor, of Indianapolis, who is now a lieutenant colonel, and is the director of the X-ray Section of the Service School at the Brooke General Hospital, San Antonio, Texas. Congratulations, Colonel Taylor!

Dr. D. G. Tweedall, of Evansville, has been promoted to a captain and is at McClelland Field headquarters base of the Sacramento, California, Air Service Command. Captain Tweedall is assistant flight surgeon and chief of the physical examination section there.

Dr. Clarence H. Marchant, of Bloomington, who is serving as a captain in the United States Army Medical Corps, was home to spend Christmas with his family while on a ten-day leave of absence. Dr. Marchant is at the head of a medical unit of doctors, dentists, nurses and medical corpsmen who have the special job of crossing the Atlantic to bring home wounded soldiers. Dr. Marchant brings word home that Germany is following the "International Rules of War" in regard to hospital and Red Cross ships.

Captain Earl W. Bailey, of Logansport, who has been in the Army Medical Corps since August, 1942, has been home on a thirty-day leave, after having become ill in North Africa where he served for thirteen months. Captain Bailey was stationed in a hospital on the coast of North Africa, and he said that almost as many Naval and Marine patients were brought there as Army wounded. Captain Bailey was flown to South America, and then to Miami, Florida. At the expiration of his leave, he will serve at the General Hospital at Rome, Georgia.

The War Department has announced that Captain Urban F. D. Stork, of Evansville, has been promoted to a major.

An interesting letter has been received from Captain O. R. Wilson, of Shelbyville, who is now stationed in the Territory of Hawaii. We quote, in part, from his letter:

"For the information of any of our classmates who may be interested, Captain Fred Dick, Jr., graduate of I.U. '37, is also stationed here and serves as laboratory officer, while I am on the medical service. We have been really working out this way for the past few weeks. We have our share of tropical diseases, but for myself I would trade all this experience for some of Indiana's chronic sinusitis."

We have a letter from Captain William R. Tipton, of Greencastle (we note that he is now a captain), informing us that he is now with the Station Hospital at Love Field, Texas. We quote from his letter as follows:

"Just a short note to bring you up to date on my address. I certainly don't wish to miss any issues of THE JOURNAL. The section on Military News is the one that most of us in the service turn to first. We all like to know where our former classmates and former colleagues are now located.

"During my six months here I have come to the conclusion that each Texan considers himself a one-man Chamber of Commerce, and the praises they drawl about this patch of waste land make the horn-tooting of the California and Florida Chamber of Commerce sound hollow. Just give me Indiana, and especially that little city of Greencastle where I used to have a twenty-four-hour day instead of the present 8:00 A.M. to 5:00 P.M."

Major Richard N. Washburn, of Rensselaer, recently has been assigned head of the medical service advisory group of one of England's major military hospitals.

Sidney Price, M.D., of Marion, has been promoted to the rank of captain in the Medical Corps of the United States Army. Captain Price is at present stationed at Camp Stoneman, California.

Captain James W. Crain, of St. Meinrad, a commanding officer of a medical hospital ship platoon, was in THE JOURNAL office recently, while home on leave of absence. He has been overseas for four months and reported having met several Indiana folk while abroad. He met Captain Art Adams in Italy; Captain Thomas S. Shields, of Indianapolis, while in North Africa, and Nurse Haller, of the Indianapolis City Hospital, in Tunisia.

Doctor M. I. Hewitt, of South Bend, is now a major in the Army Medical Corps.

Major R. B. Stout, of Elkhart, has taken off to the North Pacific. He is the head of the Surgical Division of a station hospital and supervises the X-ray, General, Orthopedic, Urologic and E.E.N.T. Surgical service.

Captain John W. Little, Jr., of Indianapolis, has been made the commander of an Army medical unit which is establishing a convalescent and rehabilitation hospital within reasonable proximity to battle lines. Captain Little's company was given credit for having worked out a system of battlefield medical stations which will serve as an intermediary between hospitalization and return to duty. Captain Little, after joining the army, was given additional training in medical and surgical practice at Carlisle Barracks, Pennsylvania, with emphasis on actual combat conditions.

Captain Francis Sheehan, of Indianapolis, is one of the doctors serving in advanced hospitals near the fighting fronts in Italy who are performing "miracles" in saving the lives of United States soldiers. He has seen action in North Africa and Sicily, as well as Italy.

Another member of Captain Sheehan's unit is Captain Kenneth I. Sheek, of Greenwood.

An Associated Press writer, with the Fifth Army, writes as follows:

"Miracles of surgery are being performed every day by frontline physicians operating under hardships which seemingly would defeat any hope of saving lives. Yet these doctors have come to accept the impossible as the normal.

"Many of these doctors have almost forgotten what it is like to operate in a warm, sterile room with indirect lights and everything neatly ordered, but they are developing skill which will give America many great surgeons when the war is ended."

Captain Sheehan, at the time the article was written, was in an advanced hospital unit in a little Italian village. The unit had taken over a house and converted it into a temporary hospital—temporary because when the unit moves the hospital also will move.

The receiving ward was a small room with an open fireplace in which logs were burning to take the dampness from the air. The kitchen was converted into a dispensary and first aid room. Winding stone steps led to second floor "wards," where a dozen patients on cots were waiting to be taken to a clearing station.

One room was set aside as an operating room, and the operating table was a rough wooden table.

"This is kitchen surgery in the rough," Major Ivan J. Roggen, Maurice, Iowa, who was in charge of the unit, explained.

News Notes

Louis J. Downey, M.D., of Vincennes, has accepted a position as a member of the medical staff at the Indiana Boys School, Plainfield.

* * *

Albert Goodrich, M.D., of Bloomington, will close his offices on December twenty-second and go to New York City to continue his medical studies.

* * *

At the final 1943 session of the county commissioners at Greensburg, H. S. McKee, M.D., of Greensburg, was appointed county physician, a position left vacant by the death of Dr. P. C. Bentle.

* * *

Mayor Robert H. Tyndall has named Dr. Leonard A. Ensminger, of Indianapolis, as one of the first five-member board of directors to manage the City Hospital at Indianapolis.

* * *

E. G. Lukemeyer, M.D., of Huntingburg, who for many years was surgeon for the Southern Railway, was the honor guest at a dinner given on his eighty-fourth birthday anniversary.

* * *

The policy of Mount Vernon physicians to have one doctor on duty on Sunday, to give other physicians needed rest, will be continued during the year 1944.

* * *

County health commissioner, Oscar Heller, M.D., of Greenfield, has submitted his resignation to the county board of commissioners. The increase in his regular medical practice has forced Dr. Heller to devote all of his time to his practice.

* * *

Bloomington has lost one of its younger physicians, Albert Goodrich, M.D., who had been practicing in the offices of Neal Baxter, M.D. He has left for New York where he will continue his medical education at Columbia University.

* * *

Wm. L. Green, M.D., of Pekin, is now located at Kalamazoo, Michigan, where he is again engaging in the practice of medicine. Dr. Green contracted arthritis while he was in the Navy, and was given a medical discharge last June. He is returning to private life after a year in the Samoan Islands.

Appointment of Dr. Larue D. Carter and Dr. John A. M. Aspy, of Indianapolis, as members of the City Merit Commission was announced yesterday by Mayor Robert H. Tyndall.

* * *

J. C. Stafford, M.D., of Plainfield, who has been the Indiana Boys School physician since his son, Lieutenant William C. Stafford, left, has resigned from his position.

* * *

Dr. Albert Fisher, of North Judson, has been appointed County Health Officer for Starke County. Dr. Fisher succeeds Dr. William J. Solt, of San Pierre, who has retired from active business life.

* * *

Announcement has been made that H. F. Carpentier, M.D., formerly of Indianapolis, on December fourteenth, 1943, began the practice of medicine and surgery in the office of Major R. S. McElroy, at 116 South Main Street, Princeton, Indiana.

* * *

Dr. Richard P. Gripe, of Indianapolis, and Miss Jean L. Thompson, of Indianapolis, were married in the Irvington Presbyterian Church on January fourth. Dr. Gripe was graduated from the Indiana University School of Medicine, Indianapolis.

* * *

Dr. Charles S. Stewart, of Auburn, received his fifty-second annual pass from the Baltimore and Ohio railroad. Dr. Stewart is the oldest member of the Baltimore and Ohio Surgeons Association and the only charter member living.

* * *

Dr. Charles W. Myers, of Indianapolis, has been reappointed as superintendent of the City Hospital by the newly-appointed hospital board of directors. The board also reappointed Dr. Kenneth G. Kohlstaedt, of Indianapolis, as assistant superintendent.

* * *

With the addition of the military unit at the Rose Polytechnic Institute and the quartering of many Army students at the school, the institute has among its officers of administration three Terre Haute doctors, including Dr. Paul J. Bronson, Dr. Milton M. Rubin and Dr. Allen H. Lee.

NORTHERN TRI-STATE MEETING

The Northern Tri-State Medical Association will hold its Seventy-first Annual Meeting at Toledo, Ohio, on April 11, 1944.

J. C. Glackman, M.D., formerly of Aspen, Colorado, plans to make his future home in Rockport, where he will re-open his office.

The American Board of Ophthalmology has moved its executive office to P.O. Box 1940, Portland 2, Maine. The officers thereof reported that the 1944 examinations will be held in New York City, June 3 and 4, and in Chicago, October 5, 6 and 7.

Dr. C. B. Goodwin, of Kendallville, recently received greetings from Dr. Irving S. Cutter, who writes a daily "How to Keep Well" column for the *Chicago Tribune*, congratulating him on the fine work and service he is rendering to Kendallville. Although eighty-one years of age, Dr. Goodwin is very active in the medical field.

We apologize to Dr. G. W. Gustafson, of Indianapolis, for the error which occurred in our January issue in which he was reported as being at Geneva, Nebraska. It was a clear case of mistaken identity, Dr. Gustafson's name being confused with that of another person whose name was reported to us. At any rate, Dr. Gustafson is still here.

SIXTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

A panel discussion on postwar industrial health, in which representatives of industry, labor, government, insurance companies and the medical profession will participate, will be one of the highlights of the Sixth Annual Congress on Industrial Health of the American Medical Association, to be held February 15 and 16, at the Palmer House, in Chicago. The moderator for the discussion, which will be held Tuesday morning, February 15, will be R. L. Sensenich, M.D., of South Bend, Indiana.

SOCIAL HYGIENE MEETING

The Indianapolis Social Hygiene Association and the American Social Hygiene Association are sponsoring a one-day conference, to be held at the Claypool Hotel, Indianapolis, on February 24, 1944. The purpose of this conference is to bring to the attention of the citizens of Indianapolis and Indiana the social hygiene problems that have been accentuated by the war, so that all efforts of the community can be directed toward abating these problems. The field of health and medicine will be represented by the following speakers: Drs. Thurman B. Rice, George W. Bowman, Herman G. Morgan, Normal M. Beatty, A. F. Weyerbacher and Hugh Wilkerson.

EXAMINATIONS OF AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 12, 1944, at 2:00 P. M. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

ANNUAL CLINICAL CONFERENCE INAUGURATED BY CHICAGO MEDICAL SOCIETY

The Council of the Chicago Medical Society, appreciating that Chicago is a medical center offering abundant clinical material and able clinicians, is sponsoring an Annual Clinical Conference at the Stevens Hotel, March 14, 15, 16 and 17.

Plans have been made for four intensive Post-graduate Days, consisting of half-hour lecture and clinic periods, beginning at 8:00 A.M., and continuing until 5:30 P.M., each day with intermissions for luncheons and inspection of technical and scientific exhibits. Several one hour "Panels" have been arranged. Popular subjects will be covered by specialists in their respective fields.

A dinner will be held on Wednesday evening with a speaker of national reputation on some non-medical subject.

The Chicago Medical Society believes such a four-day conference will be helpful as a wartime measure to its members and to the profession of the Middle West. All scientific sessions will be held in the Grand Ball Room of the Stevens Hotel. Registration fee will be five dollars.

It is advisable to make room reservations early.

KELLOGG FOUNDATION GRANTS \$35,000 FOR POSTWAR STUDY

The Board of Trustees of the Kellogg Foundation has voted a grant of \$35,000 for study by the Post-War Planning Committee of the American Hospital Association of the postwar hospitalization needs of America. The worth of this project had already been recognized by a grant of the same amount from the Commonwealth Fund, contingent upon securing the balance of the \$100,000 two-year budget from other sources. The Board of Trustees of the American Hospital Association has voted \$15,000 this period.

The research of this two-year program will seek to determine the adequacy of distribution of present hospital facilities and the best method of insuring adequate hospital care for all citizens. While existing data will be utilized to the fullest extent, conclusions on a nation-wide basis require surveys on a more detailed scale. Recommendations for postwar hospital needs must be considered in the light of racial and climatic differences, relative standards of living, and other varying factors which need analysis.

UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed \$500" for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals, and to urologists who have been in such specific practice for not more than five years. The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, June 19 - June 22, 1944, Hotel Jefferson, St. Louis, Missouri. Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1944.

REFRESHER COURSE IN OTOLARYNGOLOGY

The Department of Otolaryngology of the University of Illinois College of Medicine announces its spring refresher course, to be held at the College in Chicago, March 20 to 25 inclusive, 1944. The course will be largely didactic, but some clinical demonstrations have been included. It is intended primarily for specialists, who under existing conditions are able to devote only a brief period to post-graduate review study. The fee is fifty dollars. Registration will be limited. In letter requesting application, state school and year of graduation; also give details concerning specialty training and experience. Address—Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago, Illinois.

INDIANA UNIVERSITY NEWS NOTES

The gift to the Indiana University Medical Center by Mrs. Luella Hutchins of Indianapolis, widow of the late Dr. Frank Frazier Hutchins, noted authority on mental and nervous diseases, of a portion of his library, has been announced.

The volumes composing the gift will be retained in a separate library unit as a memorial to Dr. Hutchins who served for thirty-two years as a member of the faculty of the Indiana University School of Medicine and its predecessor institution, the State College of Physicians and Surgeons.

"The gift by Mrs. Hutchins is a distinct contribution to the advancement of medical education," said Dr. W. D. Gatch, dean of the School of Medicine. "Through use of the library accumulated over the years by Dr. Hutchins, students of medicine will be enabled to become more proficient in the treatment and care of those suffering from mental and nervous diseases—a field in which much study is being done at the Medical Center under the leadership of Dr. David Boyd.

Dr. Hutchins became a member of the faculty of the State College of Physicians and Surgeons when it was organized in 1906, and when the Indiana Medical College was united with the Indiana University School of Medicine in 1908 under the name of the latter he became the head of the Department of Mental and Nervous Diseases.

By appointment of Dr. William Lowe Bryan, then president of the University, Dr. Hutchins served as a member of the committee which worked out the organization of the faculty of the two schools after a trip east to study on the ground the organizational plans of medical schools at Johns Hopkins, Harvard and Pennsylvania universities. Without compensation Dr. Hutchins served as departmental chairman until his retirement in 1938. His death occurred in February, 1942.

First of a series of post-graduate programs for Army and Navy medical officers stationed in Indiana was held at the Indiana University Medical Center January tenth, under the sponsorship of the Indiana Committee for Post-Graduate Instruction of Medical Officers.

The Indiana Committee consists of Dean W. D. Gatch of the Indiana University School of Medicine, chairman, and Drs. Robert M. Moore of Indianapolis, and Herman M. Baker of Evansville. Lectures on the initial program included "Hypertension" by Dr. Kenneth Kohlstaedt, of the Lilly Laboratory of Clinical Research, Indianapolis City Hospital; "Effects of Abdominal Distention," by Dean Gatch, and "Pathological Specimens and X-Ray Films," by Dr. C. G. Culbertson, chief of the Medical Center's clinical and research laboratories, and Drs. Arthur P. Echternacht and John A. Campbell, radiologists on the Medical Center staff.

Dr. Edwin N. Kime, of the Indiana University School of Medicine, and Dean William N. Crawford, of the Indiana University School of Dentistry, have received from the Army Fifth Service Command appointments as the medical and dental student selection consultants for the state of Indiana.

The two Indiana University men under their Army appointments will recommend students from the Army specialized training program to receive pre-professional training and later to be admitted to medical and dental training. The institutions in Indiana having A.S.T. units from which students will be chosen include Indiana and Purdue universities, Rose Polytechnic Institute, and Ball State Teachers College.

Prior to interview and recommendation by Drs. Crawford and Kime, Army trainees will have received qualifying scores on medical-dental aptitude tests. Those recommended for pre-professional training will make a pool from which the Army will fill 80 per cent of medical school and 55 per cent of the dental school admission quotas after January 1, 1945. The remainder of the admission quotas of each medical and dental school will be reserved for civilian students.

POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of February, 1919)

The scientific section carried four articles, headed by a discussion on "War Neuroses," by Hugh T. Patrick of Chicago. Other articles were "The Present Status of Radium Therapy," by T. C. Kennedy, Indianapolis; "The Industrial Clinic," by M. A. Austin, Anderson; "Infant Conservation," by Ada Schweitzer, Indianapolis.

* * *

Editorially, the etiology of post-influenzal pneumonia was under discussion, reports from French bacteriologists who were investigating the problem being featured in the discussion.

A second editorial considered the coming session of the American Medical Association, to be held in Atlantic City, June 9-13, and to be known as "The Victory Session." This session was to be held under the direction of the War Department, this plan having been evolved so that foreign countries might accept invitations for delegates thereof to attend.

Another editorial dealt with the coming Fifth Victory Liberty Loan, urging physicians not only to subscribe liberally but to "spread the gospel" among their patients.

* * *

Several Indiana members of the armed forces, returning to their native state, had asked THE JOURNAL for assistance in finding new locations—many of them seeking newer fields for the resumption of their practice.

* * *

A discussion of the use of the term "doctor" was reprinted from *The Pennsylvania Medical Journal*. This article commented upon the fact that the term meant little to medical men in those days, since most everybody used the title for one reason or another. Editor Bulson urged medical men to use as a signature, John Smith, M.D., rather than Dr. John Smith. (We have urged this same thing for years and have practiced it faithfully, but note that many do not.)

* * *

The chiropractors had made extensive preparations for the securing of special legislation in the current session of the Indiana General Assembly.

The editor, of course, was against any such proposal, terming it "class legislation."

* * *

Edgar Cox, prominent Kokomo physician, had lost his life while on a fishing expedition at Winterhaven, Florida.

* * *

Joseph H. Ward, colored physician from Indianapolis, had been promoted to major; he was connected with Base Hospital No. 49, in service in France.

* * *

Dr. Claude B. Paynter had been elected as secretary of the Washington County Medical Society.

* * *

Frank B. Wynn had been elected as president of the Indiana Nature Study Club.

* * *

Major General William C. Gorgas, Surgeon General of the United States Army, had been named to the French Legion of Honor.

* * *

The Hendricks County Medical Society, at their annual meeting, had voted to retain W. T. Lawson, of Danville, as their secretary. (Doctor Lawson continues in that capacity, with the longest such service record in Indiana.)

* * *

Physicians recently discharged from service and returned to their native Indiana were: C. F. Hope, Coatesville; C. E. Savery, South Bend; R. S. Gailbraith, Huntington; Fletcher Gardner, Bloomington; C. H. White, Mooresville; B. J. Larkin, Indianapolis; W. D. Calvin, Fort Wayne.

* * *

The Council of the Indiana State Medical Association had voted to remit dues of members who were in the armed services as of January 1, 1919. The Council also had passed a resolution calling on the Indiana University School of Medicine to appoint a committee to make a study of the "merits" of any new cult.



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Deaths



Lieutenant Klee

DIED IN MILITARY SERVICE

Lieutenant Kurt Benjamin Klee, of Indianapolis, was killed in action in the North African area on July 10, 1943. He was commissioned a first lieutenant in the Medical Reserve Corps, United States Army, on September 19, 1941; began extended active duty on April 10, 1942, being assigned to the Aviation Cadet Board in Boston, and served with the Paratrooper Division. He was posthumously awarded the Purple Heart on October 5, 1943.

Ora L. Stephenson, M.D., of Indianapolis, died at a local hospital on December seventeenth, at the age of seventy-eight. He was a graduate of the Medical College of Indiana, Indianapolis, in 1891.

Harry Miller, M.D., of Morristown, died on January second, at the age of seventy-six. He graduated from the Medical College of Indiana, Indianapolis, in 1891.

R. R. Trueblood, M.D., a native of Monroe City, died January fifth from a heart attack. Dr. Trueblood was sixty-nine years of age. He graduated from the Hospital College of Medicine, Louisville, Kentucky, in 1896.

Perry C. Bentle, M.D., of Greensburg, died December nineteenth, at the age of sixty-six years. He graduated from the Medical College of Indiana, Indianapolis, in 1904. Dr. Bentle, in addition to serving as president of the Decatur County Medical Society and as head of the Fourth District Medical Society, was a member of the Indiana State Medical Association and was a Fellow of the American Medical Association.

James A. Craig, M.D., of Greenwood, died during the month of December at the age of seventy-two years, after having practiced medicine in the Greenwood area for nearly half a century. He graduated from the Medical College of Indiana, Indianapolis, in 1894. He specialized in proctology. Dr. Craig was a member of the Johnson County Medical Society, the Indiana State Medical Association, and the American Medical Association.

William Frederick Schenk, M.D., of New Corydon, died November twenty-eighth at the age of seventy-seven. Doctor Schenk was a graduate of the Curtis Physio-Medical Institute, Marion, in 1896.

Andrew R. Wyatt, M.D., of Fort Wayne, died December nineteenth, at the age of eighty-eight years. He was graduated from the Physio-Medical College of Indiana, Indianapolis, in 1881. Dr. Wyatt was a member of the Allen County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Wilbur O. Jenkins, M.D., formerly of Terre Haute, died in Indianapolis on December third at the age of eighty-two. He graduated from the Medical College of Ohio, in 1884. Doctor Jenkins was a member of the Vigo County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

James W. Milligan, M.D., of North Madison, died January fifth, at the age of eighty-five. He was a graduate of Rush Medical College, University of Chicago, in 1889. At the time of his death, Dr. Milligan had served as medical superintendent of the Madison State Hospital for twenty-nine years, and had been in state institutional work for forty-seven years. He had limited his practice to psychiatry, and was a member of the American Psychiatric Association. Dr. Milligan was a member of the Jefferson County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Wm. F. Willien, M.D., of Indianapolis, died December fourteenth, at the age of sixty-nine. He was graduated from the Medical College of Indiana, Indianapolis, in 1898.

David White, M.D., of Tobinsport, died December twenty-sixth, at the age of seventy-seven. He graduated from the University of Louisville School of Medicine in 1890.

McKinley J. Bohannon, M.D., of Terre Haute, died December thirteenth, at the age of forty-seven. He was a member of the 1934 graduating class of the Indiana University School of Medicine, Indianapolis. Dr. Bohannon was a member of the Vigo County Medical Society, the Indiana State Medical Association, and the American Medical Association.

John H. Allin, M.D., of Fishers, died in an Indianapolis hospital on November twenty-second. He was eighty-one years of age. Doctor Allin graduated from the Medical Faculty of Trinity University, Ontario, Canada, in 1896.

William H. Williams, M.D., of Lebanon, died January thirteenth at the age of seventy-five. He graduated from the Medical College of Indiana, Indianapolis, in 1897. Dr. Williams was the founder of the first modern general hospital in Boone County. He was a member of the Boone County Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association. He also was a member of the American College of Surgeons.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:10 A. M., Sunday, January 9, 1944, in Private Dining Room No. 2 of the Columbia Club, Indianapolis, with Dr. Floyd T. Romberger, of Lafayette, chairman, presiding. Roll call showed 100 per cent attendance, as follows:

Members of the Council:

First District	—I. C. Barclay, Evansville
Second District	—H. C. Wadsworth, Washington
Third District	—A. P. Hauss, New Albany
Fourth District	—J. C. Elliott, Guilford
Fifth District	—A. M. Mitchell, Terre Haute
Sixth District	—Samuel Kennedy, Shelbyville
Seventh District	—Walter L. Portteus, Franklin
Eighth District	—E. H. Clauser, Muncie
Ninth District	—Floyd T. Romberger, Lafayette
Tenth District	—W. H. Howard, Hammond
Eleventh District	—Ira Perry, North Manchester
Twelfth District	—H. L. Murdock, Fort Wayne
Thirteenth District	—Alfred Ellison, South Bend

Officers:

C. H. McCaskey, Indianapolis, president 1943
 J. T. Oliphant, Farmersburg, president 1944
 N. K. Forster, Hammond, president-elect
 A. F. Weyerbacher, Indianapolis, treasurer
 E. M. Shanklin, Hammond, editor of *THE JOURNAL*
 C. A. Nafe, Indianapolis, chairman, Executive Committee
 T. A. Hendricks, executive secretary

Dr. Forster introduced Dr. William H. Howard of Hammond, new councilor of the Tenth District.

Dr. Walter L. Portteus of Franklin, president of the Seventh District Medical Society, who is serving as councilor of the Seventh District in the absence of Lieutenant Colonel C. J. Clark, was introduced by Dr. Nafe.

On the motion of Dr. Wadsworth, seconded by Dr. Mitchell, the reading of the minutes of the September 28 and September 30, 1943, meetings of the Council, held at Indianapolis, was dispensed with, as these minutes were approved as printed in the November issue of *THE JOURNAL*.

REPORTS OF COUNCILORS BY DISTRICTS

A brief, informal report was made by each councilor, indicating that all of the districts are functioning and in good condition. In addition, the following remarks were made:

DR. A. P. HAUSS, 3rd District:

"Mr. Chairman and Members of The Council:

"I have the following report as councilor of the Third District.

"The Third District has had no meeting since the spring of 1942. Following the state meeting in September, the Floyd County Medical Society extended an invitation to the district society to meet at New Albany, but due to the protracted illness of the District chairman, Dr. Henderson Miller of West Baden, no fall meeting was held. We are now planning to hold a spring meeting at New Albany the latter part of March or the first part of April. The meeting and dinner will be held at Silvercrest, southern Indiana Tuberculosis Sanitarium.

"I find that there is much organization work to be done in my district. Last week when I received a copy of the suggested program for this midwinter meeting of the Council, I immediately contacted by long distance phone the secretary of each of the nine county societies in my district, and submitted to them an informal questionnaire on the following subjects:

- (1) County Society meetings.
- (2) County Society annual elections.
- (3) Medical relief payments.

(4) Maternal and child-welfare care for servicemen's families.

(5) County speakers on Wagner-Murray-Dingell Bill.

(6) Incidental comments on 1944 state program.

A summary of this district survey is as follows:

(1) County Society meetings—

Two counties are holding regular monthly meetings. Three counties are meeting every second month. Four counties have held only one or two meetings during 1943. Attendance at meetings average about $\frac{1}{3}$ of active membership.

(2) County Society elections—

Two county societies have elected officers for 1944. One county in December, 1941, elected officers to serve for the duration, and they have had but one meeting since that time. The secretaries of the other six counties promised this councilor that they would try to hold an election during the present month.

(3) Medical relief payments—

Present method of payment of medical fees is generally satisfactory in the district. Only one county preferred the old township trustee system. Several counties reported that their only complaint was 'In cases when the patient died, the doctor could not collect for the final illness.' However, one of the highly respected clear thinkers of our district, when questioned on this point, said, 'It is true, we do lose some of these final fees, but that's all right; we are perfectly satisfied in our county with the present system. Direct payment to the doctor by the state is State Medicine.'

(4) Maternal and child welfare care for servicemen's families universally considered a necessary evil—

All county society physicians were reported as cooperating, except two or three physicians in the district. One county reported that they had had no requests for this government-provided service. Another county reported government fees were larger than they would probably receive from these servicemen's wives as private patients. All counties objected to the lengthy detailed reports they must fill out in these cases and considered them an unnecessary burden on the overworked physicians, and a delay to adequate service.

(5) Wagner-Murray-Dingell Bill county speakers—

The doctors in the Third District are too busy and overworked to prepare and deliver speeches. Only two counties said that they might have one or two men for this service. They all feel that this work is primarily the responsibility of the state association and the American Medical Association, and that we should start an active and aggressive State and National public campaign.

(6) Incidental Comment on 1944 Annual Session Program—

Instructional courses:	Yes.
Commercial Exhibits:	Yes.
Scientific Exhibits:	Yes.
Golf, trap and skeet shoot:	No.
Stag party:	Yes.
Dinner for Women Physicians:	Why?
Annual banquet:	Yes.
Class & fraternity luncheons:	No.
Thursday morning scientific meeting:	No.

"Mr. Chairman, your councilor from the Third District plans to visit each county society in the district during the present year, sincerely endeavoring to carry on the work of his distinguished predecessor, Lieutenant Colonel Wm. H. Garner, now with the armed forces, and he is pleased to serve a district that is truly representative of American Medicine and has contributed more than 33 per cent of its active membership to the armed forces."

Dr. F. T. Romberger, 9th District—"Tippecanoe County of the Ninth District, as you all received newspaper notice, had a spread in our *Courier-Journal* in regard to the Wagner-Murray-Dingell Bill, which attracted attention throughout the country. In fact, we got many very fine complimentary letters. The National Physicians' Committee reproduced it and sent it to every county medical society and every daily newspaper in the United States. The National Physicians' Committee will furnish a mat to any county society which wants to print that article in its newspaper exactly as we printed it in Tippecanoe County."

Dr. Alfred Ellison, 13th District—"We held the annual meeting the eighth of last month. Sister Kenny was the speaker of the evening. She is obviously a mental as well as a physical giant. We had an attendance of about four hundred, which is the largest district meeting we have had, and I believe one of the largest ever held in the state. In addition to having the physicians of the district and their wives, we invited representatives of various interested lay groups, such as the Children's Welfare Board, Tuberculosis League, Crippled Children's Society, et cetera. In addition to these, we had the attendance of three members from the committee of the State Legislature appointed to select a site for a crippled children's hospital in northern Indiana. Also Tom Hendricks, Carl McCaskey, and Ira Perry were good enough to attend. The meeting was a real success.

T. A. Hendricks, executive secretary—"I had the pleasure of attending that meeting with Dr. McCaskey, president of the state medical society. We both thought that it was one of the best meetings ever held, from the standpoint of contacts made with various representative groups in that district. Such a meeting is the best type of public relations work that can be done by a medical organization."

District meetings were reported scheduled as follows for 1944:

First District	Not set
Second District	Not set
Third District	March or April, New Albany
Fourth District	May, 1944, North Vernon
Fifth District	Not set
Sixth District	May 18, 1944, Greenfield
Seventh District	November, 1944, Franklin
Eighth District	Muncie
Ninth District	May 24, 1944, Crawfordsville
Tenth District	Hammond
Eleventh District	May 17, 1944, Wabash
Twelfth District	Not set
Thirteenth District	Not set

The chairman asked that councilors notify the headquarters' office immediately when dates of their district meetings are set. This is particularly advisable this year because an industrial health conference is to be held in April or May, and district meetings should not conflict with the industrial health meeting or with the annual session of the American Medical Association which will be held June 12 to 16, 1944, at Chicago.

REPORTS OF OFFICERS

Dr. J. T. Oliphant, president 1944—See page 83 for complete talk.

Dr. N. K. Forster, president-elect—"I have no formal report to make at this time, but I do have a lot of hopes that with our combined efforts we can solve many of the problems that are now facing us."

Dr. C. H. McCaskey, president 1943—"I have no special report to make. All the report I care to make has been made in *THE JOURNAL* and to the House of Delegates and the general meeting. I am very happy to have been a co-worker with you gentlemen during the past year and other years, and I know you are going to carry on in a fine, keen fashion."

Dr. E. M. Shanklin, editor of *THE JOURNAL*—"To use the old trite saying, you have had a report from *THE JOURNAL* every thirty days during the last year and you know almost as much about it as we do. However, I do want to say that 1943, I think, was a big year for *THE JOURNAL*."

"Physically, *THE JOURNAL* has had some problems and will have other problems of considerable more magnitude . . .

"We have had several special numbers during the year, such as the Conservation of Vision and the Pearl Harbor number, the latter, I believe, being the outstanding issue of the year in medical journalism in this country."

"Soon after the present setup took over *THE JOURNAL* in 1933, we had a letter from Morris Fishbein in which he stated something like this, 'I have been looking over your journal and find that its scientific section carries on about as in former years, but I note that *THE JOURNAL* has lost its militant flavor. It is not the militant journal

that Dr. Bulson used to publish.' Now, we are not a militant journal, yet we have gone out for this and that, but as time has gone on things have come up in the medical economic picture which it seems to us we might talk about, and we have done some talking on those things. I do not believe that the American Medical Association would write *THE JOURNAL* on January 9, 1944, and say that we are no longer militant. The inner pages of the December *JOURNAL*, covering the 1943 session of this association, would operate against any idea that we of Indiana are no longer militant. *THE JOURNAL*, through its pages has held no punches, and yet we have not gone out and created a tirade against the parent organization. We have been critical on some things, but the officers of this association and the members of the House of Delegates have had occasion to talk out loud, particularly at the last meeting of our House of Delegates. The chairman of your Council made some statements at that meeting of the House of Delegates to which an A.M.A. official took very great personal exception. I am sorry that the answer of the chairman of your Council has not been in the hands of every member of the state association before this. I consider it the real masterpiece of writing that has come to my ears since I have been connected with this association, a matter of forty-two years.

"I spoke of, and am very glad to hear Dr. Oliphant mention that the parent organization has said a decided 'No' to all plans of sickness and hospital insurance that have been presented to them."

Dr. A. F. Weyerbacher, treasurer, presented the following report which was compiled by George S. Olive and Company, certified public accountants:

TREASURER'S REPORT

January 7, 1944.

The Council,
Indiana State Medical Association,
Indianapolis, Indiana.

Gentlemen:

We have examined the cash records of your Association for the year ended December 31, 1943. This examination was undertaken for the purpose of determining and verifying the cash transactions for the year, and of verifying the assets and liabilities at the close of the year, as recorded on the records.

The results of our examination are presented in this report, which includes: (1) text of comments; (2) statement of assets of all funds at December 31, 1943; (3) statements of receipts and disbursements of all funds, year ended December 31, 1943. A list of the statements is presented on the first page following this text.

General Comments

In exhibit A is presented an analysis of the decrease in assets of the Association for the year ended December 31, 1943, showing in summary form the sources from which this decrease was derived.

The decrease of \$6,746.85 is largely accounted for by the reduction of membership dues, caused by an increasing number of members going to the armed forces and thereby being exempt from dues. This fact is readily seen by a study of exhibit C, which also shows an increase in a few disbursements made from the general fund, two of which are an increase in public policy expense of \$1,752.69 and an increase of \$2,054.64 in the annual session expense.

Details of the assets of all funds are presented in exhibit B. Since there were no recorded liabilities at December 31, 1943, the assets as shown represent the surplus of each fund at that date. We have examined the securities of the Association, and confirmed bank balances by direct correspondence with the depositories.

Details of the cash receipts and disbursements of the general fund, of THE JOURNAL of The Indiana State Medical Association and of the Medical Defense fund are presented in exhibits C, D, and E.

Yours very truly,
GEO. S. OLIVE & COMPANY,
Certified Public Accountants.

Indiana State Medical Association

LIST OF STATEMENTS CONTAINED IN REPORT ON
EXAMINATION OF CASH RECORDS, YEAR
ENDED DECEMBER 31, 1943

- Exhibit A—Analysis of decrease in assets, all funds, year ended December 31, 1943
- Exhibit B—Statement of assets, all funds, at December 31, 1943
- Exhibit C—Comparative statement of cash receipts and disbursements, years ended December 31, 1943, and December 31, 1942
- Exhibit D—Statement of cash receipts and disbursements of THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1943
- Exhibit E—Statement of cash receipts and disbursements of the Medical Defense fund, year ended December 31, 1943

EXHIBIT A

Indiana State Medical Association

ANALYSIS OF DECREASE IN ASSETS, ALL FUNDS,
YEAR ENDED DECEMBER 31, 1943

TOTAL ASSETS, DECEMBER 31, 1943—Exhibit B.....	\$53,145.85
TOTAL ASSETS, DECEMBER 31, 1942.....	59,892.70
NET DECREASE	\$ 6,746.85

Arising from the following sources:

Excess of operating cash disbursements over operating cash receipts, general fund, year ended December 31, 1943: Receipts—Exhibit C.....\$30,077.97 Disbursements—Exhibit C.. 35,921.30 Excess of operating disbursements	\$5,843.33
Excess of operating disbursements over operating receipts, THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1943:	

Receipts—Exhibit D.....	\$19,334.88
Disbursements—Exhibit D..	20,654.40
Excess of operating disbursements	1,319.52
Excess of operating receipts over operating disbursements, medical defense fund, year ended December 31, 1943: Receipts—Exhibit E.....\$ 2,761.75 Disbursements—Exhibit E.. 2,345.75 Excess of operating receipts	416.00
TOTAL NET DECREASE.....	\$ 6,746.85

EXHIBIT B

Indiana State Medical Association

STATEMENT OF ASSETS, ALL FUNDS,
AT DECEMBER 31, 1943

General Fund:	
Cash on deposit—Exhibit C.....	\$ 5,131.81
Petty cash fund.....	200.00
Investments:	
Marion County Flood Prevention bonds.....	\$ 3,000.00
Indianapolis City Hospital bonds	5,000.00
U. S. Treasury bonds.....	13,000.00
U. S. Savings bonds.....	5,000.00
	26,000.00
Total general fund assets	\$31,331.81
The Journal of The Indiana State Medical Association:	
Cash on deposit—Exhibit D....	1,385.82
Medical Defense Fund:	
Cash on deposit—Exhibit E....	5,428.22
Investments:	
Marion County Flood Prevention bonds.....	\$ 2,000.00
U. S. Treasury bonds.....	8,000.00
U. S. Savings bonds.....	2,000.00
U. S. Baby bonds.....	3,000.00
	15,000.00
	20,428.22
Total Assets, All Funds—Exhibit A	\$53,145.85

EXHIBIT C

Indiana State Medical Association

COMPARATIVE STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEARS ENDED DECEMBER 31, 1943,
AND DECEMBER 31, 1942

Year Ended		
Dec. 31, 1943	Dec. 31, 1942	Increase Decrease
CASH BALANCE AT BEGINNING OF YEAR		
	\$10,975.14	\$12,637.06
Receipts:		
Membership dues	23,132.00	29,621.83
Income from exhibits.....	5,455.00	3,027.50
Petty cash refund—contra.....	300.00	
Miscellaneous refunds.....	45.50	1.88
Beachton Court Liquidation Trust distribution.....	35.80	1,815.60
Rokeby Liquidation Trust distribution		307.20
Refunds of traveling expense..		222.84
		6,489.83
		2,427.50
		300.00
		43.62
		1,779.80
		307.20
		222.84

Interest income:			
U. S. Treasury bonds.....	368.75	368.75	
U. S. Savings bonds.....	87.50	25.00	62.50
Indianapolis, Indiana, City			
Hospital bonds.....	200.00	200.00	
Marion County, Indiana,			
Flood Prevention bonds....	127.50	127.50	
Instruction courses — annual			
session	169.25		169.25
Refund on 1942 convention....	156.67		156.67
Total receipts	\$30,077.97	\$35,718.10	\$5,640.13
BEGINNING BALANCE PLUS			
CASH RECEIPTS	\$41,053.11	\$48,355.16	\$7,302.05

Disbursements:

Transfer of applicable portion			
of dues to The Journal of			
The Indiana State Medical			
Association—Exhibit D	6,638.00	6,494.50	143.50
Medical defense fund — Ex-			
hibit E	2,414.25	2,364.75	49.50
Headquarters' office expense..	10,608.60	10,680.74	72.14
Publicity committee	394.96	250.81	144.15
Public policy.....	1,973.40	220.71	1,752.69
Council	6,153.25	6,265.60	112.35
Officers	521.20	439.35	81.85
Rent	500.00	500.00	
Annual session	4,049.86	1,995.22	2,054.64
Miscellaneous committees....	1,996.07	1,404.67	591.40
Post-graduate study.....		15.50	15.50
Federal O. A. B. tax.....	64.21	60.67	3.54
Military dues refunds.....	282.50	1,590.00	1,307.50
Petty cash refund—contra....	300.00		300.00
Other refunds.....	25.00	25.00	
Securities purchased.....		5,000.00	5,000.00
Sundry		72.50	72.50
Total disbursements.....	\$35,921.30	\$37,380.02	\$1,458.72

CASH BALANCE AT END OF			
YEAR	\$ 5,131.81	\$10,975.14	\$5,843.33
	(Exhibit B)		

EXHIBIT D**Indiana State Medical Association****STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS,**
YEAR ENDED DECEMBER 31, 1943**THE JOURNAL OF THE INDIANA STATE MEDICAL**
ASSOCIATION

BALANCE, JANUARY 1, 1943.....	\$ 2,705.34
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Receipts:

Subscriptions—members—Exhibit C.....	\$ 6,638.00
Subscriptions—non-members	571.43
Advertising	11,964.93
Collection on accounts receivable.....	75.00
Single copy sales.....	24.00
Electrotypes	61.52
Total receipts—Exhibit A.....	19,334.88

\$22,040.22

Disbursements:

Editorial and management salaries.....	\$ 8,387.99
Printing	9,515.47
Office postage.....	165.00
Journal postage	465.68
Press clippings.....	70.97
Electrotypes	594.28
Office rent and light.....	247.62
Office supplies	578.56

Advertising commissions.....	418.49
Federal O. A. B. tax.....	58.37
Expenses—editor and editorial board....	50.41
Sundry	101.56
Total disbursements—Exhibit A.....	20,654.40
Balance, December 31, 1943—Exhibit B.....	\$ 1,385.82

EXHIBIT E**Indiana State Medical Association****STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS,**
YEAR ENDED DECEMBER 31, 1943**MEDICAL DEFENSE FUND**

BALANCE, JANUARY 1, 1943.....	\$5,012.22
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Receipts:

Transfer of applicable portion of dues	
from the general fund—Exhibit C.....	\$2,414.25
Interest income:	
U. S. Treasury bonds.....	\$237.50
U. S. Savings bonds.....	25.00
Marion County, Indiana, Flood	
Prevention bonds.....	85.00
	347.50
Total receipts—Exhibit A.....	2,761.75
	\$7,773.97

Disbursements:

Attorney's fee	\$1,800.00
Malpractice fees	500.00
Treasurer's bond	15.00
Printing	30.75
Total disbursements—Exhibit A.....	2,345.75

Balance, December 31, 1943—Exhibit B.....	\$5,428.22
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UNFINISHED BUSINESS

(1) *Plan to carry out action of House of Delegates.*

Dr. Cleon A. Nafe, chairman, Executive Committee—"Your committee has had long and arduous regular meetings, which have been well attended, except that Dr. Asher has been unable to attend because of his illness. He tells us that he will be able to be around in a few months. He appears in excellent health now. He has gained about thirty pounds.

"Many problems have been presented to the committee. I cannot touch upon many of these in this report, but I am sure you are familiar with most of them, as they are included in the minutes of the regular meetings. There are several specific problems that the members of the Executive Committee instructed me to report to the Council with their recommendations.

"The Executive Committee was instructed at the last Council meeting to present at this meeting recommendations for broadening the activities of the state medical association as outlined by the House of Delegates. To do these things costs money, and therefore it may be well to state that during this past year the association ran at a deficit of about \$6,000.00 This was occasioned by a loss of income of approximately \$9,000.00, due to

the fact that more than nine hundred members are in the service and are not paying dues; also to increased cost of JOURNAL publication and other general increased costs, due to more activities and a generally higher basic cost of all materials. This means that we have dipped into our reserve. We still have \$52,000 of assets. Any additional increase in expenses will further deplete these assets unless further revenue is secured by an increase in membership dues.

"To meet the request of the House of Delegates, the Executive Committee recommends the following program, that the House of Delegates be informed of the cost and the true situation concerning our finances and that future plans be determined by their action:

"1. *Public relations.* The suggestion has been made that more contact should be made with lay groups, more medical publicity be undertaken, and that more speeches on the Wagner-Murray-Dingell Bill be presented by a representative of the medical society before luncheon groups, et cetera.

"The Executive Committee recommends that the personnel of the headquarters' office be increased so that Miss Kribs can be freed to do more executive work and give Mr. Hendricks more time for outside work; that our attorney, Mr. Stump, be utilized more for public speeches; that the dangers to the public of illegal cult and medical practice be stressed, and that in each councilor district at least three physicians be well trained to discuss these problems before lay groups. A school for such speakers is to be held on the morning of January 23, preceding the annual Secretaries' Conference.

"2. The Bureau of Publicity has inaugurated a series of radio broadcasts and pays one-half of the director's (Mrs. Stewart) salary, or \$100.00 per month. The Executive Committee recommends that this be continued.

"3. All of this work, as stated before, requires more help and possibly more office space. The work of the Procurement and Assignment Service takes almost all of Miss Reid's time. We recommend the employment of an additional stenographer at a salary of not to exceed \$130.00 per month.

"4. Our present employees have been very faithful, and according to present labor standards deserve much overtime pay. In line with increases in cost of living and increasing wage scales elsewhere, we recommend that Miss Rokke's salary be increased to that of her predecessor, Miss Toman, and that Miss Reid and Miss Kribs be given 10 per cent wage increases.

"5. We further recommend that the Council consider the question of a raise in salary to our efficient executive secretary, Mr. Hendricks.

"The Executive Committee recognizes that all of these proposals, if carried out, will require that our state association dues be increased from the present \$10.00 to \$15.00, or approximately that, if our budget is balanced. We recommend the above program until the next meeting of the House of

Delegates, that they be given the full responsibility of deciding the future of these activities and of meeting the cost by raising the dues."

The Chairman—"We will now take up these various recommendations of the Executive Committee in detail. They are problems of the entire Council.

Items 1 and 2, public relations, which are practically one, with reference to headquarters' personnel and taking on this part-time publicity agent, Mrs. Stewart."

Dr. Mitchell—"It is my understanding that the House of Delegates wanted us to increase our public relations activities, and since that is my understanding I think that this money should be spent and that this program should be carried out, even if we have to touch into our reserve to do it. You are not going to get action unless you employ someone to go out and do the job. I move that the Council authorize this expense."

Dr. Wadsworth—"It was ordered, wasn't it?"

The Chairman—"The Council is mandated to take on this activity. The Executive Committee, as I understand it, felt that by shifting here and shifting there and adding a little more help to the headquarters' office force, thus releasing Tom, we could get by for this year, and maybe next."

Dr. Murdock—"The question arises as to where the money will come from for this—increase of dues or use of capital reserve?"

The Chairman—"It was the opinion of the Executive Committee that we place this matter before the House of Delegates this coming fall. In the meantime, we will have to dip into this reserve."

The motion made by Dr. Mitchell was seconded by Dr. Wadsworth, and carried.

The Chairman—"The next item concerns the employment of an additional stenographer in the headquarters' office."

Dr. Ellison—"I make a motion that we employ such a stenographer." Motion seconded by Dr. Mitchell and carried.

The Chairman—"Item No. 4, increase in headquarters' salaries."

Dr. Mitchell moved that Miss Rokke's salary be increased to that which was enjoyed by Miss Toman. Motion seconded by Dr. Ellison, and carried.

Dr. Barclay moved that Miss Reid and Miss Kribs each be given a 10 per cent increase in salary. Motion seconded by Dr. Perry and Dr. Kennedy, and carried.

The Chairman—"Item No. 5, in regard to Tom's salary."

Dr. Howard made the motion that Mr. Hendricks' salary be increased \$1,000.00 per year. Motion seconded by Dr. Kennedy, and carried.

(2) *Voluntary health insurance survey.*

Dr. McCaskey—"I have nothing much to report about this other than that Dr. Nafe and I have been selected as members of the state medical association organization to meet with this group of

hospital people who are attempting to put on an insurance plan for the hospitals. We have no definite data other than that they are trying to promote the Blue Cross Hospital plan. There will be a meeting tomorrow night. We will know more about it at a very early date, and will report later."

SUGGESTIONS AND PROPOSALS FOR 1944 (95TH) ANNUAL SESSION AT INDIANAPOLIS

1. *Dates set* by the Executive Committee, Tuesday, Wednesday and Thursday, October 3, 4 and 5, 1944, approved by the Council.

2. Headquarters to be at the Murat Temple, Indianapolis.

3. It was taken by consent that the golf tournament and trap shoot should be eliminated again in 1944.

4. The Council unanimously approved emphasizing the instructional courses this year.

5. *The annual banquet* will be held either in the Riley Room, Claypool Hotel, or at the Indianapolis Athletic Club.

6. *Scientific and commercial exhibits.* Dr. Perry moved that both the commercial and scientific exhibits be continued this year. Motion seconded by Dr. Barclay, and carried.

7. *Stag party.* It was taken by consent that the stag party be held as heretofore.

8. *Women physicians' dinner.* It was moved by Dr. Wadsworth, seconded by Dr. Mitchell, and carried, that the women physicians' dinner be held.

9. *Preliminary program.* Embodying the foregoing suggestions, the preliminary program for the 1944 annual session of the Indiana State Medical Association is as follows:

Monday, October 2, 1944

Meeting of health officers.

Tuesday, October 3, 1944

Morning —Registration

Instructional courses

Commercial and scientific exhibits

Afternoon—Council meeting

Meeting of House of Delegates

Instructional courses

Evening —Smoker and stag party

Dinner for women physicians

Wednesday, October 4, 1944

Morning —General scientific meeting

Commercial and scientific exhibits

Noon —Class and fraternity get-togethers and luncheons

Afternoon—Section meetings

Evening —Annual banquet

Thursday, October 5, 1944

Morning —Final meeting of House of Delegates

Final Council meeting

Adjournment

10. *"Air Corps" meeting.* Following a discussion by Mr. Hendricks as to the "slant" the meeting should have, Dr. Ellison moved that the annual session be "slanted" toward the Air Corps, if possible. Motion seconded by Dr. Kennedy, and carried.

11. *Budget.* Dr. Wadsworth made the motion that a budget allowance of \$1,700.00 be approved for use of the local committee for convention expenses. This motion was seconded by Dr. Perry, and carried.

12. Mr. Hendricks stated that the basic cost last year at the Claypool Hotel was \$450.00 and that the basic cost at the Murat Temple might be \$1,000.00. It was taken by consent that arrangements for convention accommodations be left to the Executive Committee.

13. *Professional medical stenographers.* It was taken by consent that professional medical stenographers should be employed.

MEMBERSHIP PROBLEMS

1. *Membership report.*

MEMBERSHIP REPORT

Indiana State Medical Association

December 31, 1943

County Society	No. M.D.'s in * County	Members Dec. 31, 1943	Members Dec. 31, 1942	Loss— Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible	No. M.D.'s in ** Service
1st District										
Posey	15	12	12		2		1			4
Vanderburgh	205	146	148	—2	44	2	11	4	4	48
Warrick	20	13	12	1	1		5	1		5
Spencer	18	11	11		4		2		1	3
Perry	11	9	11	—2	2		1			
Gibson	28	26	29	—3	1		2	1		7
Pike	12	11	10	1			1			3
Total	309	228	233	—5	54	2	23	6	5	70
2nd District										
Knox	52	41	42	—1	6		4		2	4
Daviess— Martin	38	26	26		10		1	1		8
*Sullivan	28	21	22	—1	2	2	6	1		
Greene	24	19	20	—1	5					9
Owen	12	11	11		1					3
Monroe	42	37	37		5			2		13
Total	196	155	158	—3	29	2	11	4	2	37
3rd District										
Lawrence	34	23	22	1	5	1	6			8
*Orange	14	13	15	—2	1		2			2
Crawford	10	6	4	2	2			2		1
Washington	14	11	11				1	2		4
Scott	10	5	4	1	3		2			
*Clark	39	18	13	5	18	2	2		1	6
*Floyd	46	37	39	—2	5		1	2	2	10
Harrison	8	8	8							1
Dubois	21	19	20	—1	2	1		2		4
Total	196	140	136	4	36	4	14	8	3	36
4th District										
Brown										
*Bartholomew	40	29	26	3	3	1	3	2	3	8
Decatur	19	17	18	—1			2			4
Jackson	24	17	19	—2	5		1	1		4

County Society	No. M.D.'s in* County	Members Dec. 31, 1943	Members Dec. 31, 1942	Loss— Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible	No. M.D.'s in** Service
*Jennings	13	12	12				1	1		3
*Ripley	15	13	14	—1	2					3
Jefferson	23	19	19		2		4			2
Switzerland	8	7	7		1					
*Dearborn- Ohio	25	19	20	—1	2		1		3	7
Total	167	133	135	—2	15	1	12	4	6	31

5th District										
Parke-										
Vermillion	39	27	23	4	8	2	3	1	1	4
Putnam	19	17	17						2	5
Vigo	137	106	107	—1	19		10	4	7	21
Clay	20	16	17	—1			1		3	2
Total	215	166	164	2	27	2	14	5	13	32

6th District										
Hancock	26	24	19	5		5	2			9
*Henry	43	39	39		1			4	1	16
Wayne-Union	76	59	61	—2	8	1	5	2	2	19
Rush	18	15	15		2	1	3		1	2
Fayette-										
Franklin	23	19	20	—1			2			3
*Shelby	39	27	21	6	6	3	5	1		8
Total	225	183	175	8	17	10	17	7	6	57

7th District										
Hendricks	20	17	17		1		1		2	4
*Marion	883	700	646	54	142		33	6	20	217
Morgan	33	21	19	2	8	1	3		1	4
*Johnson	21	15	16	—1	6		1			3
Total	957	753	698	55	157	1	38	6	23	228

8th District										
*Madison	102	83	83		12	3	6	2	2	24
*Delaware-										
Blackford	110	80	78	2	22	4	4	1	3	29
*Jay	28	21	17	4	3	1	2	2		8
Randolph	27	23	24	—1	3		2			6
Total	267	207	202	5	40	8	14	5	5	67

9th District										
Benton	12	11	11					1	1	1
*Fountain-										
Warren	24	19	22	—3	4		2			4
*Tippecanoe	97	87	91	—4	5	1	3	5		23
*Montgomery	37	27	27		6		4	1		10
Clinton	27	22	25	—3	1		2	2		7
Tipton	16	10	11	—1	5		1	1		2
Boone	24	21	21		2	1			1	6
Hamilton	29	20	19	1	5	1	2	1	1	3
White	8	4	4		3			1		4
Total	274	221	231	—10	31	3	14	12	3	60

10th District										
Lake	316	247	244	3	57	6	9	5	5	61
Porter	31	29	26	3	2		1	1		8
Jasper-										
Newton	21	17	13	4	2	1	1	1		5
Total	368	293	283	10	61	7	11	7	5	74

County Society	No. M.D.'s in* County	Members Dec. 31, 1943	Members Dec. 31, 1942	Loss— Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible	No. M.D.'s in** Service
11th District										
Carroll	16	13	10	3	2		2			6
*Cass	56	38	39	—1	12		5	1	1	11
*Miami	29	21	22	—1	5		1	1	1	4
Wabash	33	25	24	1	2		5		1	7
Huntington	33	28	20	8	2	5	1	2	2	7
Howard	50	38	36	2	6		5		3	12
Grant	76	50	53	—3	21	1	4		3	13
Total	293	213	204	9	50	6	23	4	11	60

12th District										
LaGrange	8	7	7		1		2			
Steuben	21	10	10		8		2	1		3
*Noble	30	26	26		4			2		4
DeKalb	29	21	22	—1	6		1	2		5
Whitley	17	12	11	1	1	1	2		3	3
Allen	206	172	173	—1	19	1	7	6	8	60
*Wells	24	21	20	1	3	1	1			5
*Adams	24	20	19	1	2	1	1		1	5
Total	359	289	288	1	44	4	16	11	12	84

13th District										
*LaPorte	85	60	57	3	21	4	2	2		10
St. Joseph	187	157	149	8	17	11	9	1	7	47
*Elkhart	91	73	77	—4	13	2	6	1	1	20
Starke	7	5	4	1	2	1				1
Pulaski	8	8	8							2
Fulton	19	12	12		5		2			3
*Marshall	33	25	28	—3	2		3	1	3	8
Kosciusko	23	15	18	—3	6		4	1		
Total	453	355	353	2	66	18	26	6	11	91

Summary by Districts										
1st District	309	228	233	—5	54	2	23	6	5	70
2nd District	196	155	158	—3	29	2	11	4	2	37
3rd District	196	140	136	4	36	4	14	8	3	36
4th District	167	133	135	—2	15	1	12	4	6	31
5th District	215	166	164	2	27	2	14	5	13	32
6th District	225	183	175	8	17	10	17	7	6	57
7th District	957	753	698	55	157	1	38	6	23	228
8th District	267	207	202	5	40	8	14	5	5	67
9th District	274	221	231	—10	31	3	14	12	3	60
10th District	368	293	283	10	61	7	11	7	5	74
11th District	293	213	204	9	50	6	23	4	11	60
12th District	359	289	288	1	44	4	16	11	12	84
13th District	453	355	353	2	66	18	26	6	11	91
Total	4,279	3336	3260	76	627	68	233	85	105	927

* Physicians are listed in the counties in which they hold membership, not in the counties in which they reside.

** Military Service—927 Indiana physicians who are in service maintained a practice in the state prior to entering service and are members of the state association. In addition, 277 Indiana physicians are in service who have not practiced in the state and therefore are not association members. Total, 1,204.

Dr. Perry^o—"In how many districts does the county society secretary collect the district dues? I think that is the secret of the success in financing the district society."

NEW BUSINESS

1. Contract with editor of *The Journal*. Dr. Mitchell moved that the contract, prepared by the

attorney of the association, with Dr. Shanklin, editor of THE JOURNAL, be signed by Dr. F. T. Romberger, chairman, for the Council. Motion seconded by Dr. Wadsworth, and carried.

2. The following future medical meetings were called to the attention of the Council:

- (1) Secretaries' Conference and "School for Speakers," 10:00 A. M., Sunday, January 23, 1944, Indianapolis Athletic Club, Indianapolis.
- (2) National Conference on Medical Service, Chicago, February 13, 1944.
- (3) Indiana's Industrial Health Conference, April or May.

3. *Nominations for Editorial Board.*

Dr. Mitchell nominated Dr. Charles N. Combs of Terre Haute.

Dr. Ellison nominated Dr. F. R. N. Carter of South Bend.

Dr. Murdock nominated Dr. Bert Ellis of Indianapolis.

Dr. Clauser nominated Dr. Lall G. Montgomery of Muncie.

Dr. Murdock moved that the nominations be closed; motion seconded by Dr. Barclay, and carried.

ELECTIONS FOR 1944

1. *Executive Committee members for 1944.*

Dr. Porttous—"In view of the fact that Dr. Asher is sick and that his return is uncertain, and also in view of the fact that in these times I think it is well that the Executive Committee be 100 per cent in attendance, if possible, I would like to nominate Dr. McCaskey and Dr. Nafe for places on this committee." Nomination seconded by Dr. Ellison. Dr. Howard moved that the nominations be closed; motion seconded by Dr. Barclay, and carried.

Dr. McCaskey and Dr. Nafe were elected members of the Executive Committee for 1944.

2. *Chairman of the Council.* Upon the motion of Dr. Mitchell, seconded by Dr. Kennedy, Dr. F. T. Romberger was re-elected chairman of the Council for 1944.

LUNCHEON

Several items of an informative nature were discussed at the luncheon.

1. *Medical relief problems and suggestions.*

Dr. Ellison, member of the Medical Relief Committee of the Indiana State Medical Association, and member of the Advisory Committee on Medical Relief to the State Department of Public Welfare—"I have attended only one meeting of the medical advisory group of the Department of Public Welfare, but two matters came up which it seems might be appropriate to bring to the attention of this group. Whether or not you want to or could do

anything about it, I don't know, but as a matter of policy it is well to give these two things some thought, it seems to me.

"The administrative official of the Welfare Board pointed out that over half of the counties of our state have indicated their desire that money which is paid for medical aid be paid to the doctors rather than to the recipients. This matter was discussed at our meeting. Dr. Black, of Warren, was there. Dr. Boggs was unable to come. We pointed out that the American Medical Association for many years, and a great many doctors who have thought about this problem, advocate that such payments should be made, certainly not to the doctor direct, but to the recipient—the basic principle being that it is a form of socialization of medicine. To pay the doctor directly only helps the Government to further its program of socialization and tends to soften our members for the next step in their program.

"The state officials apparently have no desire one way or another on their part. It is pointed out that if the money is paid to the doctors, the federal government is excused from paying any of it . . . 60 and 40 per cent . . . whereas federal government pays 50 per cent, state 30 per cent, and county 20 per cent.

"The second matter I thought should be brought to your attention, as a matter of policy on the basis that it might some time come to need action on the part of the state organization, is, in each community they are finding that there are certain doctors here and there whose charges for their services to the Department of Public Welfare are sharply out of line with the average charges being made in these communities. I talked to Dr. Oliphant about these points, and he adopts a fine attitude by saying that a great many doctors do that in their private practice. Some doctors are seeing their patients two or three times a day. This thing was discussed in the welfare meeting. The feeling is that each county should have an appointed group—two or three doctors—whose function would be to serve as a liaison group between the local board and the medical profession, so that where doctors are thought to be out of line, the director, before paying bills, could take this up with the local committee. We urged them strongly to handle this thing on a local level. . . . They pointed out instances in one county where the greatest offender was the secretary of the county medical society. They thought for that reason it would be difficult to handle that problem locally. They asked whether or not the state organization should enter into the picture. It seems to me that one of the thoughts that should dictate our policies is that if somebody is definitely guilty of avarice and is going to jeopardize the general welfare of the society, it is up to the profession to get such a man to see the light of day and straighten out his conduct."

Dr. Porttous—"Just in passing, I wondered about the inconsistency of that line of reasoning. I

happen to have been on the Child and Maternal Welfare Committee last year, when we set up the maternal and child-welfare plans for taking care of servicemen's families. At that time it was agreed that the government should pay this through the state department. Then we turn around and say that the money should be given to the individual in this case and paid by the individual to the doctors. Locally, that is the plan we have at the present time. I understand that it is to be changed on the basis of the Welfare Department. They are setting up a program. They intend to have a couple of doctors on the committee. . . . In instances where the doctor failed to collect, he was to run to the welfare director and get him to bring pressure on this person to pay. We should either take a stand one way or the other instead of pussy-footing, which I think we are doing."

Dr. Ellison—"In that connection I believe it should be stated that the practice of requiring recipient's signature for each single service rendered has been abandoned and only one signature is required now, which reduces the paper work considerably."

Dr. Oliphant—"In some counties this welfare setup is left to the discretion of the county welfare boards. Some county welfare boards seem to be very sensible and reasonable about it. I live in Sullivan County—the north edge is the Vigo County line—so I practice in both counties. Sullivan County has no setup at all. The Vigo County welfare board instructed me and the other doctor in my town that if we had patients in Vigo County who were welfare patients, it would be enough for us at the end of the month to send a statement to the welfare board for our services, and on our own billhead, merely itemizing services and making our usual charge, and charge this to the patient but send it to the welfare board and they would include in the next payment to the recipient enough money to cover that bill. It is a very satisfactory way to do it, and not any different from our other practice, and I have quite a number of patients over the Vigo County line who are recipients of this old age relief, and at the end of the month my girl sends a statement to the welfare board charging the patient for this service, and the board sends the patient the money and the patient pays me."

2. Radio program.

Dr. H. G. Hamer, chairman, Bureau of Publicity—"I am to speak on the Bureau of Publicity radio program. I hardly know how to approach the mention of this matter. All of you are perfectly familiar with what we have undertaken. It seems to us that so far the project has worked out pretty satisfactorily, and we are looking forward to the year with a great deal of interest. During the month of December there were a number of broadcasts; plans for January are well under way. The Elkhart series began January 3; Lafayette, January 4; Muncie, Terre Haute, Fort Wayne, Kokomo and South Bend will begin January 16.

"I have not been able to hear any of these programs because of being occupied at the time of the broadcasts. I hope you have had better luck. I understand from Mrs. Stewart and others who are vitally interested in the thing that they are being put over in very good order.

"The program for the 'School for Speakers' for doctors who are to address lay groups on the Wagner-Murray-Dingell Bill which will precede the Secretaries' Conference on January 23 has been published in *THE JOURNAL* and you are already familiar with it. The Bureau is desirous of having a large enrollment of speakers for this program, and we would urge those of you who have to do with the procurement of speakers in the various districts to send in the names of these speakers."

3. Legislative matters.

Dr. R. L. Sensenich, member of the Board of Trustees of the American Medical Association, discussed national legislative matters.

4. Procurement and Assignment Service.

Dr. Charles R. Bird, chairman, War Participation Committee—"I shall reduce my remarks to a minimum. Procurement and Assignment Service continues with unabated momentum. The volume of business continues at a sustained level. I can see the usefulness of Procurement and Assignment projected into the demobilization period. In one form or another I am sure it will go on and that we can by no means see the beginning of the end. We have been cajoled, threatened and high-pressured from one angle or another. We have tried to keep a middle-of-the-road course.

"In the earlier activities of the Preparedness Committee we spent a good deal of the state association's money. A little later on we spent a good deal, for which we have been largely reimbursed—postage, telephone and telegraph expenses. At this time the association is bearing none of the expense pertaining to the Procurement and Assignment Service proper. We have a government telephone in the office, an extension from the Office for Emergency Management. Last year the War Participation Committee's expenditures amounted to \$968.97, \$650.00 of which was spent in behalf of 'Medsoc,' which was charged up to that committee. This year, for my budget proper I will ask for \$250.00, plus the amount which will be necessary to carry on the activities of 'Medsoc.' I believe that it is a morale builder and reports indicate that it should be continued. It is up to you men to determine whether it should be continued. If so, an additional \$700.00 should be added to the budget for 1944.

"This past week I was approached by a member of the Civil Service Commission as to providing a physician in each county to represent the United States Veterans Administration. To date, about one million men have been discharged from the armed forces. The bigger percentage of them have never had any consideration by the Veterans Ad-

ministration. All compensation claims will be adjudicated through the regional office of the Veterans Administration. They are unable to procure doctors adequately to carry on the hospital at the facility here in Indianapolis. We are confronted by the proposition of having far too few doctors, and as it is with the case of the civilian population, we can have no replacements. The Veterans Administration is not going to get doctors at a salary of \$3800 to \$4200 a year.

"When a man is processed the fifth time, and then accepted, we don't know where we are with reference to IV-F men, and we are asked to utilize IV-F men for replacements. Discharged service men with claims for compensation to be adjudicated must therefore be examined throughout the state by appointed or designated examiners.

"What they are asking through Procurement and Assignment is to set up a system whereby we would have something like the old Veterans Bureau setup, whereby there would be an examiner in each county to enable them to meet the load of making physical examinations and report to the Veterans Administration. There must be some sort of an arrangement whereby that sort of thing can be carried on. I pass it on to you, for I don't think it comes within the province of Procurement and Assignment Service. It is up to the state association to consider the matter and provide through the component county societies facilities necessary to meet the needs of the Veterans Administration, which is already overwhelmed by the growing volume of business. This matter ought to receive your immediate consideration. A request will be submitted in writing by the Veterans Administration, outlining the nature of the service they want rendered.

"There is a crying need for doctors in many localities throughout the state. In two or three instances we are asking for a man who is willing to come back."

Appreciation of Dr. E. O. Asher—Dr. Mitchell made the motion that "The executive secretary be instructed to write to Dr. Asher and express the high regard the Council has always held for his work on the Executive Committee, and wish him a speedy recovery." Motion seconded by Dr. Perry, and carried.

There being no further business, the meeting was adjourned.

THOMAS A. HENDRICKS,
Executive Secretary.

Pay your dues now!

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

December 19, 1943.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Guests: Thurman B. Rice, M.D.; Holland Thompson, M.D., and Robert Jewett, M.D., State Board of Health; Gordon Batman, M.D.; J. H. Stygall, M.D.; H. C. Ochsner, M.D.; R. C. Beeler, M.D., and Frank L. Jennings, M.D.

The statements of receipts and expenditures for November for the Association committees and THE JOURNAL were approved:

Membership Report

Number of members Dec. 18, 1943	3,335*
Number of members Dec. 18, 1942	3,256
Gain over last year	79
Number of members Dec. 31, 1942	3,260

* Includes 127 honorary members and 921 military members.

Treasurer's Office

The annual audit of the books is being made and report will be available for midwinter Council meeting.

1943 Annual Session, Indianapolis

The following report of Dr. Gordon Batman upon expenditures of the local arrangements committee was received and approved by the committee upon the motion of Dr. Romberger, seconded by Dr. McCaskey:

"Financial Report of Meeting of Indiana State Medical Association:

"Receipts from Indiana State Medical Association	\$1,200.00
"Disbursements	1,184.99

"Balance on hand

\$15.01

"In the budget permitted by the Executive Committee for the conduct of the State Convention for 1943, no provision was made for the banquet given for women physicians, held the same night as the smoker for the men physicians. The General Arrangements Committee, without further authority, granted the necessary funds for the dinner for women physicians. The cost of this item was \$73.69.

"The General Arrangements Committee also agreed to assist, if possible, in meeting any deficit incurred by the Woman's Auxiliary in the entertainment of the wives of the physicians. This deficit was \$79.88.

"In view of the approximation of these two items in amount and the oversight in making no

allowance for the entertainment of the women physicians, we hope that the Executive Committee will authorize the state treasurer to transmit the amount of \$79.88 to the treasury of the Woman's Auxiliary of the Indianapolis Medical Society."

"Instructional Course Report:

"Total receipts from admission charges \$225.00

"Expenses:

Monitors for classrooms	....	\$20.00	
Secretarial expense	.....	20.00	
Printing	.....	8.75	
Supplies and assistant expense	.....	7.00	55.75

"Balance in fund \$169.25

"It is the feeling of the General Arrangements Committee, under whose direct supervision this program of instructional courses was conducted, that this fund be placed in the treasury of the Indiana State Medical Association, but earmarked separately as available only for the further necessary expenses of the instructional course program. Though this may seem to be a very material balance, the course merits better publicity and more elaborate productions, and generally speaking can do little more than support itself as a continuing part of the state convention. We hope that this suggestion will be followed."

It was moved that an instructional course fund be created so that the surplus of \$169.25 collected from the courses during the annual session will not go into the general treasury but can be used for the courses next year.

1944 Annual Session, Indianapolis

October 3, 4 and 5, 1944, selected as dates for annual session.

Upon the motion of Dr. Oliphant, seconded by Dr. McCaskey, the headquarters are to be at the Murat Temple. It was suggested that some members of the Executive Committee talk with Dr. C. E. Cox, treasurer of the Murat Temple, in regard to arrangements.

Dr. Bert Ellis appointed general arrangements chairman by Dr. Oliphant.

Preliminary report of chairman to be presented at midwinter Council meeting January 9.

Commercial exhibit.

b. Auralgan exhibit to be accepted for 1944 upon the motion of Dr. McCaskey, seconded by Dr. Oliphant.

Legislative, Legal and Social Security Matters

National

Wagner-Murray-Dingell Bill still remains in committee, with no indication of immediate action.

a. Resolutions of New England group in regard to Wagner-Murray-Dingell Bill and prepayment medical plans brought to the attention of the committee, together with editorial that appeared in the *Connecticut State Medical Journal*. The committee was of the unanimous opinion that this is the most forthright and sanest statement in regard to the situation that has yet been presented. The committee suggested that Dr. Creighton Barker, secretary of the Connecticut State Medical Society, with the consent of Dr. A. M. Mitchell, chairman of the Committee on Secretaries' Conference, be invited to address the Secretaries' Conference.

b. *Actions by Shelby and Tippecanoe County Medical Societies*. Resolution of Shelby County Medical Society, relating "the many services rendered to the local community by its membership without thought of remuneration," brought to the attention of the committee. The committee commended this resolution highly, together with the newspaper advertisement published by the Tippecanoe County Medical Society.

c. Address by Representative Joseph W. Martin of Massachusetts, made before the District of Columbia Medical Society, entitled "America Must Not Be Shackled," brought to the attention of the committee.

d. Method of combatting Wagner-Murray-Dingell Bill in Indiana.

1. The Indiana Inter-Professional Health Council met and adopted the following resolution in regard to the Wagner-Murray-Dingell Bill: "Dr. Crockett moved that, 'the Executive Committee be directed to cooperate with other organized groups interested in preserving the traditional American values of individual freedom and initiative in science, in business, and in the professions, and join with them in promoting these common ideals.' Motion seconded by Dr. Ewbank and carried unanimously."

2. Woman's Auxiliaries in various counties are organizing meetings.

A meeting January 18 at which Dr. Morris Fishbein is to be principal speaker, sponsored by Howard County Auxiliary, will be held at Kokomo.

3. Program for "School for Speakers" to be held during annual Secretaries' Conference, January 23, 1944, approved by committee.

e. Contacts with various groups reported by Dr. John Hewitt, Dr. Oliphant, and Dr. McCaskey.

f. Report made in regard to South Bend Y.W.C.A. sponsoring the bill, according to the Y.W.C.A. Bulletin.

Relocation of physicians. Bulletin from the Bureau of Legal Medicine and Legislation of the American Medical Association in regard to legislation providing funds for the relocation of physicians brought to the attention of the committee. As finally passed in the Senate, the measure provides for \$345,000 for use "by the Public Health Service in providing medical care to civilians in

critical areas." The bill also provides that these physicians can be relocated only upon the approval of the State Board of Health. The bill will be considered in the conference committee of the House and Senate. Although the committee felt that the relocation of physicians is not the proper function of the State Board of Health, it did not see how it could take any effective action at this late date in voicing its disapproval of the bill with its Congressmen, as the bill is already in conference committee. In addition to that, the committee further felt that it probably is better to have the State Board of Health approve such relocations rather than the Welfare Department. Dr. Thurman Rice, secretary of the State Board of Health, stated that he certainly didn't want to have anything to do with such matters and that he felt that this activity does not come under the rightful duties of the State Board of Health.

Public Relations

Appointment of G. Lombard Kelly, M.D., of Augusta, Georgia, as secretary of the new Council on Medical Service and Public Relations of the American Medical Association, reported to committee.

Copies of the December JOURNAL with the articles on public relations and the actions of the House of Delegates sent to members of the Board of Trustees and the Public Relations Council of the A.M.A., and the secretaries of the various state medical societies. Copies of the discussion in regard to public relations to be sent to each member of the House of Delegates of the A.M.A.

Report made that the "Indiana Contact Plan" was approved by the Council on Medical Service and Public Relations of the A.M.A. and was distributed by the A.M.A. to the public relations committees of the various state medical organizations.

Resolution of the Michigan State Medical Society calling for the establishment of a Bureau of Information in Washington to aid the members of Congress brought to the attention of the committee.

Organization Matters

A plan of organization of the Indiana State Medical Association to coordinate and emphasize public relations was presented to the committee. The committee will hold a special meeting the evening of January 8 to complete its report which is to be made to the Council on January 9.

Committee appointments for 1944 to be announced by Dr. Oliphant in the January issue of THE JOURNAL.

Dr. Clyde Culbertson, chairman, Dr. Kenneth Kohlstaedt, and Dr. Ernest Rupel reappointed on the Scientific Exhibit Committee by the Executive Committee.

Charges preferred by the Fort Wayne Medical Society against one of its members brought to the attention of the committee.

Request received from a county medical society for an opinion as to whether proxies can be used in county medical society elections. Mr. Stump's opinion in regard to this brought to the attention of the committee.

The committee approved an increase in the amount deposited on the postage meter machine, to take care of the increase in the amount of mail sent out by the headquarters' office, and in order to avoid frequent trips to the postoffice.

State Board of Health

The tuberculosis work of the State Board of Health, which is under the direction of Dr. Holland Thompson, who recently has been appointed director of this department, was thoroughly discussed by the Executive Committee. Dr. Rice, director of the State Board of Health, Dr. J. H. Stygall, chairman of the Anti-Tuberculosis Committee of the Indiana State Medical Association, Dr. F. L. Jennings of Sunnyside Sanatorium, and Dr. Raymond Beeler and Dr. H. C. Ochsner of the local Roentgen Ray Society, discussed the work to be done by this bureau. This division of the State Board of Health was created as a result of the recommendation of the Anti-Tuberculosis Committee of the Indiana State Medical Association, which was approved by the House of Delegates.

Child and maternal care. Letter from Lake County criticising the activities of the public health nurse of Gary in the child and maternal care program brought to the attention of the committee. This letter reads as follows:

"It is the opinion of the Council of the Lake County Medical Society that the fact of pregnancy is privileged information between physician and patient, and the fact that federal assistance is requested for the pregnant wives of service men should in no way throw open to the Public Health Department or others this information. Numerous reasons were cited by the members of the Council that the pregnant wife of a member of the armed forces might have for desiring to maintain secret the fact of her pregnancy from those with whom she resides or from employees of the local health department.

"It is further believed by the Council of the Lake County Medical Society that the physician through whom the request for assistance was made is entirely competent to make whatever recommendations regarding her pregnancy are necessary without the assistance of the public health nurse.

"The Council of the Lake County Medical Society therefore protests this procedure and requests its immediate discontinuance except in those cases where the assistance of the public health nurse is individually and specifically requested either by the patient or the attending physician."

Dr. Jewett stated that this practice on the part of the public health nurses would be discontinued.

Socialized Medicine

The committee discussed answering the article criticising the medical profession which appeared in the September issue of "The Teachers College Journal," the publication of the Indiana State Teachers College at Terre Haute, Indiana. This article entitled, "An Analysis of the Opposition of the Medical Profession to Modifications in The System of Medical Care," was written by Wilbur Brookover, an instructor in Social Studies at Indiana State Teachers College, who is now serving as a lieutenant (j.g) in Washington, D.C., with the Educational Services Program of the Navy. The committee suggested that Dr. Oliphant answer this criticism.

Letter from Dr. Asher in regard to this subject brought to the attention of the committee.

Group Hospitalization and Voluntary Sickness Insurance

The Indiana Hospital Association has been active in forming a group hospitalization organization in Indiana without waiting for legislation. The Executive Committee approved a letter written by Dr. Nafe and Dr. McCaskey requesting a meeting and a complete discussion in regard to the plans in order that a report may be made back to the Executive Committee concerning the formation of such plans in Indiana.

The committee adjourned, to meet again January 8, 1944.

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

December 10, 1943

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D.; Walter P. Morton, M.D., president, Indianapolis Medical Society; Mrs. Lotys Stewart, and T. A. Hendricks, executive secretary.

The release, "Health on Your Christmas Shopping List," was approved for publication on December 12.

The Bureau discussed questions on radio broadcasting. The Bureau felt that for the present it should not accept time on a commercial hour, such as was offered it by one company. The Bureau is of the opinion that it could accept time upon hours used by non-commercial organizations, when requested to do so by such organizations. The Bureau is of the opinion that physicians in private practice should not have their names announced over the radio except when broadcasting as an officer or an official of a medical organization upon a subject which does not reflect their specialties.

Radio schedule for December:

Station WISH:

December 3—Health Examinations in Schools

" 10—Influenza

" 17—Health and Juvenile Delinquency

" 24—Three Doctors

" 31—Medicine in '43

Station WIRE:

December 12—History of Medical Education in Indiana

Radio plans for January:

Station WTRC, Elkhart—

Series begins January 3, Mondays, 8:15 P.M.

Station WBAA, Lafayette—

Series begins January 4, Tuesdays, 5:15 P.M.

Arrangements now being made with other stations for series on "Your Health in War-time."

Program on "Health of Women in Industry" to be presented over Station WISH.

Requests for speakers:

Dec. 17—Seventh District Medical Society, Martinsville. Discussion of Wagner-Murray-Dingell Bill.

Dec. 17—Cass County Medical Society, Logansport. Speaker obtained to talk on "Industrial Health."

Jan. 4—Indianapolis Medical Society, Indianapolis. Discussion of Wagner-Murray-Dingell Bill.

The Bureau approved the material for the Woman's Auxiliary kit.

Letter from the president of the Woman's Auxiliary to the Lake County Medical Society approved for publication in THE JOURNAL.

Pamphlet from the Y.W.C.A. at South Bend, approving the Wagner - Murray - Dingell Bill, brought to the attention of the Bureau.

The Bureau was informed that the Governor had appointed a World War II Historical Committee and would desire the cooperation of the medical profession.

The president for 1944 of the Indiana State Medical Association consolidated the historical and necrology committees and made them one committee.

Letter approved by Bureau to be sent to councilors, asking them to suggest speakers on the Wagner-Murray-Dingell Bill.

Socialized Medicine questionnaire that appeared in *The Indiana Farmers Guide* brought to the attention of the Bureau. Ray Everson, editor of *The Farmers Guide*, reported that this questionnaire showed better than 90 per cent return against socialized medicine.

COUNTY SOCIETIES

COUNTY MEDICAL SOCIETY OFFICERS

CLAY COUNTY MEDICAL SOCIETY:

President, Lewis C. Rentschler, Clay City
Vice-president, C. C. Sourwine, Brazil
Secretary-treasurer, Robert K. Webster, Brazil

DeKALB COUNTY MEDICAL SOCIETY:

President, Bennell Souder, Auburn
Vice-president, Dorsey M. Hines, Auburn
Secretary-treasurer, C. B. Hathaway, Butler

HAMILTON COUNTY MEDICAL SOCIETY:

President, Frank Rodenbeck, Arcadia
Vice-president, C. H. Tomlinson, Cicero
Secretary-treasurer, Andrew F. Connoy, Westfield

HOWARD COUNTY MEDICAL SOCIETY:

President, R. A. Craig, Kokomo
Vice-president, Paul W. Ferry, Kokomo
Secretary-treasurer, Elton R. Clarke, Kokomo

JACKSON COUNTY MEDICAL SOCIETY:

President, G. R. Gillespie, Brownstown
Vice-president, Louis H. Osterman, Seymour
Secretary-treasurer, G. H. Kamman, Seymour

JENNINGS COUNTY MEDICAL SOCIETY:

President, W. H. Stemm, North Vernon
Vice-president, John H. Green, North Vernon
Secretary-treasurer, D. L. McAuliffe, North Vernon

LaGRANGE COUNTY MEDICAL SOCIETY:

President, Clarence Shultz, LaGrange
Vice-president, Harley Flannigan, LaGrange
Secretary-treasurer, Alfred A. Wade, Howe

MADISON COUNTY MEDICAL SOCIETY:

President, Cecil S. Wright, Anderson
Vice-president, R. O. Zierer, Anderson
Secretary-treasurer, M. A. Austin, Anderson

MARSHALL COUNTY MEDICAL SOCIETY:

President, Maurice O. Klingler, Plymouth
Vice-president, C. G. Mackey, Culver
Secretary-treasurer, L. W. Vore, Plymouth

MONTGOMERY COUNTY MEDICAL SOCIETY:

President, H. D. Kindell, New Richmond
Vice-president, C. B. Parker, Wingate
Secretary-treasurer, Wemple Dodds, Crawfordsville

ORANGE COUNTY MEDICAL SOCIETY:

President, John K. Spears, Paoli
Secretary-treasurer, Clarence E. Boyd, West Baden

PORTER COUNTY MEDICAL SOCIETY:

President, J. F. Take, Valparaiso
Vice-president, Charles H. DeWitt, Valparaiso
Secretary-treasurer, John R. Frank, Valparaiso

PUTNAM COUNTY MEDICAL SOCIETY:

President, V. Earle Wiseman, Greencastle
Vice-president, G. F. Parker, Greencastle
Secretary-treasurer, G. F. Parker, Greencastle

SHELBY COUNTY MEDICAL SOCIETY:

President, Paul R. Tindall, Shelbyville
Vice-president, V. C. Patten, Morristown
Secretary-treasurer, J. A. Davis, Flat Rock

SPENCER COUNTY MEDICAL SOCIETY:

President, C. L. Springstun, Chrisney
Vice-president, C. D. Ehrman, Rockport
Secretary-treasurer, John H. Barrow, Dale

STEBEN COUNTY MEDICAL SOCIETY:

President, L. L. Eberhart, Angola
Vice-president, B. A. Blosser, Fremont
Secretary-treasurer, W. H. Lane, Angola

ST. JOSEPH COUNTY MEDICAL SOCIETY:

President, Alfred Ellison, South Bend
Vice-president, Lawrence F. Fisher, South Bend
Secretary-treasurer, K. L. Olson, South Bend

TIPPECANOE COUNTY MEDICAL SOCIETY:

President, H. E. Klepinger, Lafayette
Vice-president, H. G. Martin, Lafayette
Secretary-treasurer, J. C. Burkle, West Lafayette

WARRICK COUNTY MEDICAL SOCIETY:

President, L. S. Taylor, Elberfeld
Secretary-treasurer, DeWitt Loomis, Boonville

LOCAL SOCIETY REPORTS

100% IN PAYMENT OF 1944 DUES

Gibson County
Owen County

Adams County Medical Society members held a meeting at the Adams County Memorial Hospital, at Decatur, on December eighth. The program consisted of a general discussion of current medical problems. Seven members were present.

Bartholomew County Medical Society members held a meeting at the Chamber of Commerce Building, in Columbus, on December twenty-ninth. This was a business meeting, with election of officers for 1944. Major Byron K. Zaring, a member of the society, attended the meeting and made an impromptu talk. The Wagner-Murray-Dingell Bill was discussed. Fourteen members attended the meeting.

Clay County Medical Society members met at Aydelottes Restaurant in Brazil on December fourteenth. Officers were elected for 1944, and the program was devoted to an extensive discussion of the Wagner-Murray-Dingell Bill. Ten members were in attendance at this meeting.

Dekalb County Medical Society members held a business meeting on December ninth at the Auburn Hotel, in Auburn, for the election of officers. Fourteen members were in attendance.

Delaware-Blackford County Medical Society members met at the Ball Memorial Hospital, in Muncie, on December twenty-eighth. Dr. L. G. Montgomery discussed the Wagner-Murray-Dingell Bill. Fifteen members attended the meeting.

Fort Wayne County Medical Society members and the Woman's Auxiliary entertained more than one hundred guests at their annual Christmas party and dinner, held at the Fort Wayne Woman's Club on December twenty-first. Richard Mills, of Indianapolis, was the speaker of the evening.

Grant County Medical Society members held a business meeting on December second, at the Marion General Hospital, for the election of officers. Eleven members attended this meeting.

(Continued on page xxiii)

(Continued from page 108)

Greene County Medical Society members met for their regular business session on December sixteenth. The meeting was held at the Freeman Greene County Hospital, at Linton. Ten members were present at the meeting.

Howard County Medical Society members met at the St. Joseph Memorial Hospital, Kokomo, on January seventh, for a discussion of topics affecting the medical profession: Socialized Medicine and the Wagner-Murray-Dingell Bill; Selective Service Examinations, and Maternal and Child-Health Program. Fifteen members attended the meeting.

Indianapolis (Marion County) Medical Society members held a meeting at the Indianapolis Athletic Club on January fourth. The Presidential Address was given by Dr. William P. Morton, and colored movies were presented by Dr. William E. Gabe.

On January eleventh another meeting was held at which the subject, "Neuropsychiatric Problems Resulting from Army Service," was presented by Captain John C. Thurrott, M.C., of Fort Benjamin Harrison. Dr. Larue D. Carter, of Indianapolis, and Captain Sprague H. Gardiner, of Fort Benjamin Harrison, discussed the paper.

At a meeting held January eighteenth Dr. J. O. Ritchey and Dr. Raymond C. Beeler discussed "Some of the Problems of the Mediastinum"; and Dr. George Garceau and Dr. E. Vernon Hahn discussed "Ruptured Nucleus Pulposus."

On January twenty-eighth a round table discussion was held on "Sulfonamide Drugs," Dr. Ernest Rupel being the moderator and Drs. Matthew Winters, G. F. Kempf, Walter Morton, W. D. Little and R. A. Solomon taking part in the discussion.

Jackson County Medical Society members held a meeting on December seventeenth. Since the completion of the addition to the Jackson County Schneck Memorial Hospital, their meetings are being held there. Dr. F. E. Boys, of Indianapolis, spoke on "Treatment of Common Colds." Three medical officers of the Freeman Air Field took part in the subjects discussed, namely, Captain Lovas, Captain Martin and Captain Griffiths.

Lake County Medical Society members held a meeting at the Woodmar Country Club, in Hammond, on December ninth, with election of officers for 1944.

LaPorte County Medical Society members met at the Sheridan Beach Hotel, Michigan City, on November tenth. They were entertained with motion pictures on "Continuous Caudal Anesthesia in Obstetrics." There were nineteen members present.

PROFESSIONAL PROTECTION



In addition to our Professional Liability Policy for private practice we issue a special

MILITARY POLICY
to the profession in the
Armed Forces
REDUCED PREMIUM

THE

MEDICAL PROTECTIVE COMPANY

OF

FORT WAYNE, INDIANA

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

(In affiliation with COOK COUNTY HOSPITAL)
Incorporated not for profit

ANNOUNCES CONTINUOUS COURSES

SURGERY—Two Weeks Intensive Course in Surgical Technique starting February 7, 21, and every two weeks throughout the year.

MEDICINE—Two Weeks Course Gastro-Enterology starting June 5. Two Weeks Intensive Course Internal Medicine starts June 19.

GYNECOLOGY—Two Weeks Intensive Course starting February 7 and April 3. One Week Personal Course Vaginal Approach to Pelvic Surgery starting April 17.

OBSTETRICS—Two Weeks Intensive Course starting February 21 and April 17.

ANESTHESIA—Two Weeks Course Regional and Intravenous Anesthesia.

GASTROSCOPY—Personal Course starting April 3, June 19, and October 16.

OTOLARYNGOLOGY—Two Weeks Intensive Course starting April 3.

ROENTGENOLOGY—Courses in X-ray Interpretation, Fluoroscopy, Deep X-ray Therapy every week.

UROLOGY—Two Weeks Course and One Month Course available every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL.

Address: Registrar, 427 South Honore Street,
Chicago 12, Illinois

On December sixteenth they met at the Rumley Hotel, LaPorte. "Refrigeration Anesthesia," was discussed by Captain Harry E. Mock, Jr., of Chicago.

Miami County Medical Society members held their annual dinner meeting at Dukes Memorial Hospital, in Kokomo, on December twenty-ninth. Officers were elected for 1944.

Noble County Medical Society members held a meeting at the Publix Cafe, in Kendallville, on December fourteenth. Thirteen members attended the meeting.

Parke-Vermillion County Medical Society members held a meeting at the Vermillion County Hospital, at Clinton, on December fifteenth. Dr. A. M. Mitchell, of Terre Haute, spoke on "Legislative Problems Facing Medical Societies." Sixteen members attended the meeting.

St. Joseph County Medical Society members met at the Indiana Club, South Bend, on January eleventh. Public Relations were discussed. Forty-two members and guests attended the meeting.

Tipppecanoe County Medical Society members met at the Lincoln Lodge, Lafayette, on December fourteenth, with thirty-one members present. This was a business meeting, and officers were elected for 1944.

COUNCILOR DISTRICT REPORT

Thirteenth District Medical Society Meeting

On December eighth the Thirteenth District Medical Society held a meeting in the Oliver Hotel, at South Bend. Sister Elizabeth Kenny, famed Australian nurse, spoke on "The Treatment of Infantile Paralysis."

We quote from the *Madison County Medical Society Bulletin*, as follows:

"Despite the fact that 30 per cent of our members are now in service, the Madison County Medical Society has carried on with its regular meetings, both interesting and instructive. We have an active membership of fifty-three, and twenty-five are serving the military needs of our Army and Navy all over the world. We are trying as best we can to carry the load that at times seems burdensome, but when we think how much greater sacrifice these others have made in leaving their homes and their families, we should feel ashamed of any complaints we are prone to make. While they are fighting in the mud and rain and cold of Italy and the hell of warfare from land and sky, in the jungles and rain and swamps of the South Pacific with its malaria, typhus and other diseases, we sometimes fail to think of the fact that we know nothing of cold and hunger, lack of companionship and entertainment, and still live in a civilized

community where we must admit too many are unaware of the fact that we are fighting a war of survival—a war that asks for and gives no quarter to either the guilty or the innocent."

WOMAN'S AUXILIARY

to the

Indiana State Medical Association

President—Mrs. James Baxter, Jr., New Albany
 President-elect—Mrs. F. M. Gastineau, Indianapolis
 Corresponding Secretary—Mrs. John Habermel, New Albany
 Treasurer—Mrs. A. W. Ratcliffe, Evansville
 Press and Publicity—Mrs. A. B. Richter, Indianapolis

The mid-year meeting of the Board of Directors of the Woman's Auxiliary to the American Medical Association was held at the Palmer House, in Chicago, on November 19, 1943, with the president, Mrs. Eben J. Carey, presiding. There were forty-three members present.

Guest speakers at the meeting were Dr. Herman L. Kretschmer, Chicago, President-elect of the American Medical Association; Dr. Ralph A. Fenton, Oregon, member of the Advisory Council; Dr. William F. Braasch, Minnesota, member of the Advisory Council; Commander Max E. Lapham, executive director of Procurement and Assignment; Miss Jean Henerson, chief of the Public Relations Division of Nurse Education, U.S. Public Health Service.

Dr. Kretschmer emphasized three important points: (1) The need for increasing *Hygeia* subscriptions as an end toward perpetual health education; (2) Cooperation in the drive to register every graduate nurse in the United States; (3) The importance of having the medical profession point out to their patients the undesirable features of the Wagner-Murray-Dingell Bill.

Dr. Fenton particularly asked the members of the Auxiliary to do what they can to assist the families of young doctors in the service, and to help them when they return home.

The twenty-second annual meeting of the Woman's Auxiliary, which was scheduled for St. Louis, has been changed to Chicago with headquarters at the Knickerbocker Hotel. The dates are June twelfth to fifteenth.

ALLEN COUNTY

The Woman's Auxiliary to the Allen County Medical Society undertook the sponsorship of the Christmas Seal booth for one week in Wolf and Dessauer's store in Fort Wayne. Mrs. Sterling P. Hoffman of the Auxiliary arranged the details for the booth. The Tuberculosis Association of Allen County sponsored the campaign in Fort Wayne.

The Auxiliary assisted the Fort Wayne Medical Society with the annual Christmas party which was held on December twenty-first at the Fort Wayne Woman's Club. There were 100 members and guests present. Invited honored guests were

women living in the Fort Wayne locality whose husbands are doctors now serving in the armed forces.

Dr. J. L. Wyatt, president of the Medical Society, introduced Richard Mills, a humorist, of Indianapolis, who spoke following the dinner. Dr. M. H. Draper served as master of ceremonies for the old-time dancing which followed.

DELAWARE-BLACKFORD COUNTY

The first meeting of the year for the Woman's Auxiliary to the Delaware-Blackford County Medical Society was held on October 12, 1943, at the home of Mrs. Arthur C. Rettig, at 7:30 p. m. Mrs. U. G. Poland, president, presided. Five meetings will be held as follows: October, December, February, April, and the last meeting in either May or early June.

Mrs. Poland requested the secretary to secure names and addresses of all members who are with their husbands in service at this time. She asked that we try to give more time to Red Cross work. Miss Nellie G. Brown, superintendent of the Ball Memorial Hospital, explained the State-wide Hospital Service Plan. Mrs. Thomas R. Owens, State Secretary, gave a report on the state meeting and the Wagner-Murray-Dingell Bill.

VIGO COUNTY

The Auxiliary to the Vigo County Medical Society held the annual guest dinner meeting at 6:30 o'clock on January 11 at the Woman's Department Club. Following the dinner, which was for members of the auxiliary and their guests, Mrs. Grace Moorhead gave the evening's program, the reading of a play.

BOOKS RECEIVED

THE 1943 YEAR BOOK OF INDUSTRIAL AND ORTHOPEDIC SURGERY. By Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. 440 pages with 306 illustrations. Fabrikoid. Price \$3.00. The Year Book Publishers, Incorporated, Chicago, 1943.

OFFICE TREATMENT OF THE NOSE, THROAT AND EAR. By Abraham R. Hollender, M.D., Associate Professor of

Laryngology, Rhinology and Otolaryngology, University of Illinois College of Medicine; Otolaryngologist, Research and Educational Hospitals, Chicago, Illinois. 480 pages with numerous illustrations. Cloth. Price \$5.00. The Year Book Publishers, Incorporated, Chicago, 1943.

NASCENT ENDOCRINE THERAPY. By John Franklin Ritter, M.D. 317 pages. Fabrikoid. The Caxton Printers, Ltd., Caldwell, Idaho, 1940.

THE ARTHROPATHIES. A HANDBOOK OF ROENTGEN DIAGNOSIS. By Alfred A de Lorimier, M.D., Colonel, Medical Corps, United States Army; Commandant, The Army School of Roentgenology, Memphis, Tennessee. 319 pages. Cloth. Price \$5.50. The Year Book Publishers, Inc., Chicago, 1943.

THE 1943 YEAR BOOK OF GENERAL MEDICINE. By George F. Dick, M.D., J. Burns Amberson, Jr., M.D., George R. Minor, M.D., William B. Castle, M.D., William D. Stroud, M.D. and George B. Eusterman, M.D. 784 pages with 118 illustrations. Cloth. Price \$3.00. The Year Book Publishers, Inc., Chicago, 1943.

SPECIALTIES IN MEDICAL PRACTICE (Loose-leaf). By Edgar Van Nuys Allen, M.D., Chief of a Section in the Division of Medicine, The Mayo Clinic, Rochester, Minnesota; Associate Professor of Medicine, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. Thomas Nelson & Sons, New York City, 1943.

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report, December, 1943

	Dec. 1943	Nov. 1943	Oct. 1943	Dec. 1942	Dec. 1941
Diseases					
Tuberculosis, Primary	21	14	1	2	0
Tuberculosis, Active	300	128	326	870	74
Tuberculosis, Arrested	16	26	42	7	5
Chickenpox	222	314	205	342	271
Measles	460	407	186	178	86
Scarlet Fever	239	265	281	195	353
Smallpox	3	9	2	20	11
Typhoid Fever	3	2	12	4	6
Whooping Cough	92	111	109	71	92
Diphtheria	32	67	66	24	32
Influenza	2,431	65	28	47	116
Pneumonia	42	26	34	109	79
Mumps	74	115	49	189	26
Nonepidemic Meningitis	1	0	0	0	0
Cerebrospinal Meningitis	25	13	23	9	2
Rubella	120	8	4	33	3
Tularemia	5	2	0	8	67
Malaria	1	3	12	0	0
Undulant Fever	3	5	8	2	2

THE CHICAGO MEDICAL SOCIETY'S ANNUAL CLINICAL CONFERENCE
Stevens Hotel, March 14, 15, 16, and 17

Because of the added work imposed on physicians by the war, an intensive post-graduate conference is being arranged. The various subjects will be presented in the most practical way so as to be of immediate assistance to physicians in their daily practice. Men in service, as well as distinguished leaders in civilian practice, will take part in the program.

Wednesday evening will be given over to a banquet addressed by a non-medical man on a subject of interest to the ladies as well as to the physicians.

Final programs will be mailed to every physician in the state.

Registration fee, \$5.00.

Hotel reservations should be made early.



Pin-up picture for the man who "can't afford" to buy an extra War Bond!

YOU'VE HEARD PEOPLE SAY: "I can't afford to buy an extra War Bond." Perhaps you've said it yourself . . . without realizing what a ridiculous thing it is to say to men who are dying.

Yet it *is* ridiculous, when you think about it. Because today, with national income at an all-time record high . . . with people making more money than ever before . . . with less and less of things to spend money for . . . practically every one of us has extra dollars in his pocket.

The very *least* that *you* can do is to buy an

extra \$100 War Bond . . . above and beyond the Bonds you are now buying or had planned to buy. In fact, if you take stock of your resources, you will probably find that you can buy an *extra* \$200 . . . or \$300 . . . or even \$500 worth of War Bonds.

Sounds like more than you "can afford?" Well, young soldiers can't afford to die, either . . . yet they do it when called upon. So is it too much to ask of us that we invest more of our money in War Bonds . . . the best investment in the world today? Is that too much to ask?

Let's all **BACK THE ATTACK**



Because of the importance of the above message, this space has been contributed by

Indiana State Medical Association

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1021 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

MARCH, 1944

NUMBER 3

CEREBRAL ARTERIOGRAPHY*

CAPTAIN SIDNEY W. GROSS†

Medical Corps, Army of the United States.

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The radiographic visualization of the cerebral blood vessels by means of injecting an opaque substance into the common or internal carotid artery is known as cerebral arteriography or angiography. This diagnostic procedure has never been widely employed because of its inherent technical difficulties and the toxicity and potential dangers of the material first advocated for cerebral arteriography.

Egas Moniz,¹ of Lisbon, devised the method for the visualization of the cerebral blood vessels in 1927. He experimented with several radiopaque substances, but finally recommended a colloidal preparation of thorium dioxide, thorotrast, as the most suitable. The disadvantages and dangers in the use of this drug soon became evident. Once injected into the blood stream thorium compounds are not excreted but are deposited in the cells of the reticulo-endothelial system, especially of the liver and the spleen, where they remain indefinitely. Thorium compounds are radioactive. Their tendency to produce necrotic and malignant changes in tissues is well known. Ekström and Lindgren² attributed cerebral injuries following arteriography to the use of thorotrast. They demonstrated the presence of thorium histologically in the intravascular tissues in twenty-one brains. In six specimens they found multiple injuries in the cerebral parenchyma due to occlusion of small blood vessels by thorium dioxide. These investigators concluded that the use of thorium dioxide was an important contributory factor in the death of several of the patients in their series.

In addition to the potential hazards in the use of thorium compounds, the technical difficulties inherent in the procedure itself discouraged many from making use of cerebral arteriography. In order to popularize cerebral arteriography, the first hurdle had to be surmounted. Egas Moniz experimented with inorganic iodine compounds but gave them up as too irritating. In 1939 Robb and Steinberg³ used an organic iodide, diodrast, for the visualization of the chambers of the heart, pulmonary circulation, and great blood vessels in man. The success of their technic and the absence of severe reactions and the complete and rapid excretion of diodrast prompted me to investigate the use of this substance for the visualization of the cerebral circulation in dogs.⁴ Excellent x-ray photographs were obtained and the animals suffered no immediate or late ill effects. It was therefore considered safe to apply this technic clinically. Results during the past four years have proved the harmlessness of a 35 per cent solution of diodrast as a radiographic agent for cerebral arteriography.

Diodrast, (3,5 diiodo-4-pyridon-N-acetic acid diethanolamine) is an organic iodide of high molecular weight. It contains about 50 per cent of iodine. It has been used for intravenous pyelography for many years. Diodrast must not be confused with the colloidal thorium dioxide preparation, thorotrast. Although they have similar-sounding names, they are entirely different chemically and pharmacologically. Diodrast is non-toxic in the quantities used for arteriography except for persons who have a hypersensitivity to the drug. It is rapidly ex-

* Presented before the Wartime Graduate Medical Meeting of Billings General Hospital and the Indianapolis Medical Society, September 8, 1943.

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¹ Egas Moniz: *L'angiographie cérébrale*, Paris, Masson & Cie, 1934.

² Ekström, G., and Lindgren, A. G. H.: Cerebral Injuries After Arteriography of the Brain with Thorotrast, *Acta chir. Scandinav.*, **82**:291-302, 1939.

³ Robb, G. P., and Steinberg, I.: Visualization of the Chambers of the Heart, the Pulmonary Circulation, and the Great Blood Vessels in Man, *Am. J. Roentgenol.*, **41**:1-17, 1939.

⁴ Gross, S. W.: Cerebral Arteriography in the Dog and in Man with a Rapidly-Excreted Organic Iodide, *Proc. Soc. Exper. Biol. & Med.*, **42**:258-259, 1939.

creted by the kidneys, largely if not completely unchanged.

TECHNIC OF CEREBRAL ARTERIOGRAPHY

Satisfactory visualization of the cerebral blood vessels can be obtained either by injecting the internal or the common carotid arteries with the radiopaque substance. Two methods for introducing the needle into the artery are available. In the indirect technic the artery is injected through a needle puncture in the skin. I have had no experience with this method but have preferred to expose the common carotid by means of a small incision with the use of local anesthesia and inject the vessel under direct vision. After a period of trial and error the following plan has given the best results. Before the contemplated intracarotid injection of diodrast the patient should be questioned regarding asthma and other allergic disorders and hypersensitivity to iodine compounds. Contrast media are contraindicated in the presence of severe liver disease or nephritis. The day before the arteriography the patient should have an intradermal or conjunctival test to rule out hypersensitivity to diodrast. Food and fluids are withheld for six hours. An intramuscular injection of 5 grains (0.3 Gm.) of sodium phenobarbital is given thirty minutes before the actual injection of the contrast medium into the common carotid artery. The artery is exposed with the use of local anesthesia by means of a small incision just above the clavicle and parallel to it. A narrow vaseline tape is passed under the artery to isolate it from the surrounding structures. The patient's head is then placed in position for a lateral x-ray film and all preparations are made to obtain a rapid exposure on a signal from the operator. Perfect cooperation with the x-ray technician is essential. The artery is then punctured with a curved 17-gauge needle having a rubber tubing connection (Fig. I). A syringe containing 15 cc. of a 35 per cent solution of diodrast is attached to the rubber tubing. After ensuring that the needle is within the lumen of the vessel, by permitting a small amount of blood to run into the syringe, 10 to 12 cc. of the solution is rapidly injected. The x-ray film is exposed during the injection. The exposure should not require more than one-fourth to three-eighths second. A second film should be exposed as soon as possible after the first one. The second film will often provide visualization of the cerebral veins. If the first films prove unsatisfactory, with the needle still in place a second injection may be carried out. Bleeding from the puncture in the artery usually stops as soon as the needle is withdrawn. Occasionally pressure with a warm saline-soaked sponge may be required for a few minutes. The incision is then closed with interrupted silk sutures. Following arteriography the patient is kept flat in bed for twenty-four hours.

THE NORMAL ARTERIOGRAM

Many cerebral arteriographic examinations have been done so that the normal arteriogram is fairly

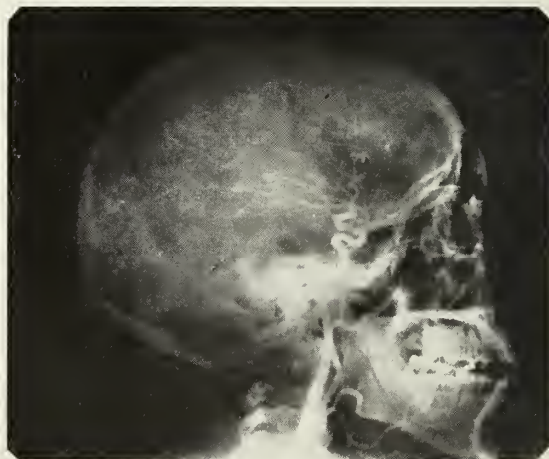
FIG. I



Cannula Inserted into Common Carotid

well known (Fig. II). Variations in the internal carotid trunk are frequent. There may be one, two or three loops. The anterior cerebral artery is always visualized and fairly uniform in position unless displaced by a tumor or abscess. The sylvian group of vessels arises from the middle cerebral artery. They may also be displaced by space-consuming lesions. The posterior cerebral artery is visualized in only about 15 per cent of arteriograms made by injecting the common carotid artery, since this vessel is normally a branch of the basilar artery and would be filled with the radiographic medium only in the presence of an unusually large posterior communicating artery.

FIG. II



Normal Arteriogram

FIG. III

*Aneurysm of the Circle of Willis*

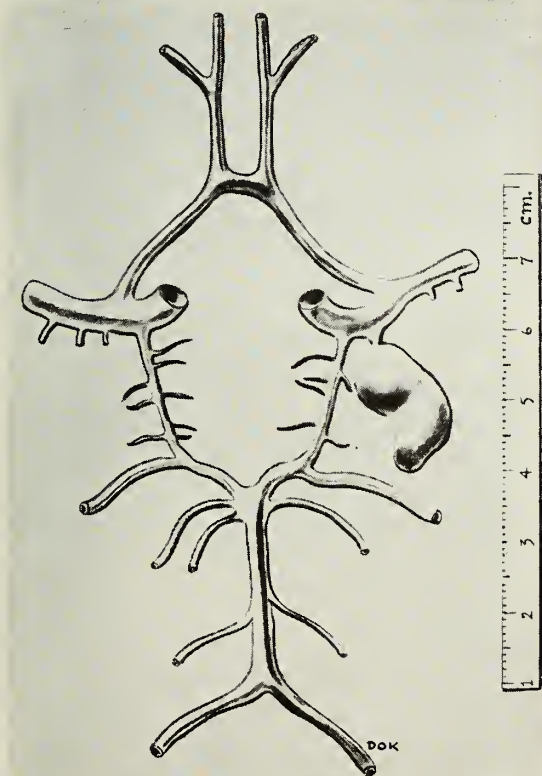
INDICATIONS FOR CEREBRAL ARTERIOGRAPHY

The development of a safe technic for cerebral arteriography and the introduction of a harmless rapidly-excreted radiopaque medium has greatly extended the application of this method.^{5, 6} Formerly

⁵Gross, S. W.: Cerebral Arteriography with Diodrast, Fifty Per Cent, *Radiology*, **37**:487-488, 1941.

⁶Gross, S. W.: Cerebral Arteriography, Its Place in Neurologic Diagnosis, *Arch. Neurol. & Psychiat.*, **46**:704-714, 1941.

FIG. IV

*Congenital Aneurysm of Circle of Willis*

cerebral arteriography was advised only when accurate diagnosis was not possible by other means. At the present time there should be no hesitation in carrying out this procedure whenever information regarding alterations in the cerebral arteries would add to the diagnosis. Cerebral arteriography is most useful in the detection and accurate localization of cerebral aneurysms (Figs. III and IV), arteriovenous fistulas, varices, vascular malformations (Fig. V), vascular tumors and other pathologic processes which implicate the intracranial blood vessels. Space-consuming lesions, such as tumors, cysts and abscesses, are localized by the deformation which they produce in the cerebral arteries. This is especially useful when for one reason or another ventriculography fails to give the needed in-

FIG. V

*Vascular Malformation*

formation. The nature of a lesion may often be suspected from the arteriogram. In cases of malignant gliomas of the brain, fine, small vessels, many of them forming a dense network with lacunar widening in the region of the tumor, are found. In meningiomas net-shaped and bundle-shaped small vessels that radiate into the tumor are readily identified. In sarcomas a combination of the findings of the two other types is found. Cysts and abscesses are diagnosed by the absence of blood vessels in the area involved. Intracranial aneurysms which simulate tumors are easily recognized by arteriography.

DISCUSSION

ROBERT GLASS, M.D. (Indianapolis): There is not very much left to say when the main speaker has given such an unusually fine presentation. I think that Captain Gross deserves considerable credit not only for an instructive and interesting presentation, but even more credit for contributing something to neurosurgery. He has made an unsafe procedure safe, and that entitles him to a certain amount of immortality.

This certainly is a procedure which strikes the imagination. You inject something into a carotid

artery, take an x-ray picture or two and then visualize the cerebral circulation. That just goes to show what is possible under modern conditions, and certainly our great-grandfathers in medical practice could never dream of a thing of this sort.

The whole aim in neurosurgical diagnosis is to state the site and the nature of the lesion. Certainly no neurosurgical procedure should be proposed or undertaken until the site and the nature of the lesion are determined as accurately as is humanly possible. There are a number of ways by which that might be accomplished. This is one method. This certainly is a very important method for that purpose, but the backlog of neurosurgical diagnosis is a good old-fashioned neurological history and a complete and thorough neurological examination. These will suffice in diagnosing with a reasonable degree of accuracy the site and degree in about two-thirds of the cases. In the other one-third of the cases they do not suffice, and it is necessary to resort to other procedures. The first of these would be the ordinary x-ray examination of the skull. That will, possibly in 10 or 15 per cent of the cases, show some change in the skull which might localize and give some very good clue as to the nature of the lesion. However, that is helpful only in about 10 or 15 per cent of the cases, and there still is a large group of cases which must be diagnosed because the lesion is an important one either threatening the life of the patient or threatening some important neurological function, such as vision or the use of one side of the body. In those cases one has to resort either to ventriculography or to this method which Captain Gross has described.

In considering the matter of special diagnosis, I think one has to bear in mind especially three points: The safety of the method, the convenience of the method, and the accuracy of the method. In regard to safety as between ventriculography and cerebral arteriography, I think that cerebral arteriography as described by Captain Gross is probably the safer procedure.

Now, from the standpoint of convenience, there probably is not much difference between the two. Both of them employ an incision, one in the scalp, one in the neck. In both procedures the patient has to be sent to x-ray for additional examination. I do not think there is much choice between the two in regard to convenience.

In regard to accuracy, I believe ventriculography has the edge in the vast majority of cases. Cerebral arteriography will possibly be more helpful in lesions involving the vascular system. Considering the great bulk of intracranial lesions which might be surgical, ventriculography would probably give more accurate information and possibly be more helpful. It might be said that many of the lesions shown here in the illustration can be diagnosed without cerebral arteriography, by neurological examination alone. Hence, this method is not necessary in all cases involving intracranial vascular lesions, and yet at times it certainly would be invaluable.

I want again to say that Doctor Gross needs a great deal of credit for making an unsafe procedure safe.

LARUE D. CARTER, M.D. (Indianapolis): I greatly appreciate Captain Gross' paper and Dr. Glass' discussion. This will aid us in determining the location of tumors and cerebro-vascular lesions.

CAPTAIN GROSS: I want to thank the discussers for their participation. I hope that Dr. Glass did not understand that I use arteriography in place of ventriculography. Arteriography is used only in those cases where a vascular lesion is suspected and where the location of that lesion is not possible on clinical examination, for instance, a young person with recurrent attacks of subarachnoid hemorrhage. Eventually one of the hemorrhages is going to be large enough to carry the patient off, and yet in many there is no clue as to the location of the bleeding vessel. In such cases arteriography is of inestimable value in localizing the lesion.

ABSTRACT: REPORT GAS GANGRENE TREATED SUCCESSFULLY WITH PENICILLIN

The successful treatment with penicillin of a case of gas gangrene is reported by W. B. McKnight, M.D.; Richard D. Loewenberg, M.D., and Virginia L. Wright, M.D., Portola, Calif., in *The Journal of the American Medical Association* for February 5. The authors say that it was recently stated that penicillin, experimentally, is a potent agent in gas bacillus infections, but up to that time there had been no studies on human cases.

The importance of the report is emphasized by the fact that although gas gangrene is a comparatively rare infection in civilian life, it is a serious menace in military operations. The mortality rate in civilian cases has been estimated at 49.7 per cent while the death rate from the infection in the American Expeditionary Forces in France in the last war was 48.52 per cent.

The three California physicians report that "We observed a severe gas infection in a seven year old girl. After all routine measures, including serums, sulfonamides and amputation, had failed, Dr. Chester Keefer (chairman of the committee of the Division of Medical

Sciences of the National Research Council which has charge of the allocation of penicillin) provided us with penicillin in sufficient quantities to treat successfully the patient, whose outlook seemed hopeless. The isolation of our mountain hospital made it unprepared and unequipped to furnish exhaustive laboratory studies. The clinical significance of our observation, however, remains important enough to justify more investigations of this treatment."

The girl was found lying on the porch of her home with a fractured left forearm, in the middle of which was a bleeding puncture wound. It could not be determined how or when she had fallen. She was immediately taken to the hospital and sulfathiazole powder was sprinkled on the wound which was sterile dressed. Four days later gas gangrene had developed to the point where amputation was necessary but there continued to be little improvement. On the seventh day after the accident penicillin treatment was started and exactly one month after the accident the girl was sent home.

INDICATIONS FOR PARACENTESIS OF THE ANTERIOR CHAMBER*

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From your eyes I read the question: "Why choose as a topic the indications for paracentesis of the anterior chamber when the opposite procedure, namely, inflation of the anterior chamber, would seem a much more timely subject?" My answer would be that inflation of the anterior chamber, while it may seem a drastic and almost revolutionary measure to some of you, does deserve our fullest attention. My experience with it, however, has been so limited that I do not have the courage to make it the subject of an official presentation.

Paracenteses are done generally for one of the following three purposes:

1. To remove undesirable material from the anterior chamber.
2. To lower the intra-ocular pressure temporarily.
3. To remove the blood-aqueous barrier temporarily.

Very little has to be said about point 1. Few hemorrhages into the anterior chamber have to be removed surgically. An important lesson in my life has been the distinction between stubbornly persistent and recurrent hemorrhages. The latter obviously do not call for surgical removal. Hemorrhages are persistent if the iris is very atrophic, covered by a homogeneous membrane or entirely absent. The absorption of hyphemas is then either very slow or an impossibility, making surgical interference necessary. Another indication for surgical removal of a hyphema is persistent elevation of intra-ocular pressure during the first few days following a severe contusion of the eyeball.

Among the foreign bodies which may be carried into the anterior chamber during injuries or operations, there are a few which, because of their chemical inertness, do not have to be removed. Such substances are droplets of petrolatum or cotton fibers, which are not infrequently found in the anterior chamber after cataract operations which have entailed irrigation of the anterior chamber.

Most paracenteses are done to lower the abnormally high intra-ocular pressure. It has long been known that in certain glaucomas paracentesis is at least temporarily effective, whereas in other glaucomas it does not bring about any relief whatsoever. In order to understand the factors which determine the responsiveness of a given eye to the paracentesis, it might be well to review the behavior of the normal eye. The phenomena described in the following were observed after anterior chamber punctures made with a hypodermic needle to which a tuberculin syringe had been at-

tached. Thus the aqueous can be removed slowly and without any abrupt drop in intra-ocular pressure. Small keratome incisions act more or less the same way as needle punctures. Again the decompression of the eye is relatively slow and the incision becomes water-tight almost immediately. After large keratome incisions, especially if they are a little bit ragged, and after incisions made at right angles to the corneal surface (keratotomy) the eye usually fistulates for several hours and the behavior of the eye differs considerably from that after most needle punctures. It was surprising to me that even needle punctures did not become water-tight immediately in about 7 or 8 per cent of all the punctures performed by my associates and myself. Such fistulation usually lasts from six to twenty-four hours. The slit lamp shows a very definite spindle-shaped gaping of the entire track of the needle. If the tip of the needle is just a little bit "hooked," this fistulation is more apt to occur.

Characteristic fluctuations of the intra-ocular pressure are observed after paracentesis. Four phases may be distinguished, namely,

- a. the initial drop,
- b. the restoration time, that is the time required for the tonometric reading to reach the original level,
- c. the hypertensive phase,
- d. the hypotensive phase.

If the anterior chamber of the eye in question is of average depth, the intra-ocular pressure after aspiration of the aqueous drops to a level below the range of the ordinary tonometer. I believe that in most of these instances the pressure drops to negative values, that is values below the atmospheric pressure. The reformation of intra-ocular fluid is at first very rapid, so that in an eye with originally average chamber depth about one-half of its contents is regenerated during the first ten minutes. During the first half hour following the paracentesis at least 75 per cent of the original fluid volume is reformed. At the end of the first hour the depth of the anterior chamber is usually completely restored. The intra-ocular pressure reaches the original level a little later. From there on the non-glaucomatous eye enters the hypertensive phase. The highest tensions observed during this phase, in a large number of non-glaucomatous eyes, have been in the neighborhood of 42 mm. of mercury (Schiötz). The hypertensive phase is self-limited and merges into the hypotensive phase, which in the non-glaucomatous eye is usually slight and lasts several days. In elderly people and especially if the paracentesis is repeated at short intervals, the hypotensive phase is

* Read before the Section of Ophthalmology and Otolaryngology of the Indiana State Medical Association, September 29, 1943.

more pronounced than after single paracentesis in young individuals. The effect of the paracentesis upon the blood-aqueous barrier can be studied most easily by determining the protein content of the reformed aqueous. Immediately after the puncture the contents of the anterior chamber may contain as much as 400 or even 500 milligram per cent of protein, which is 20 to 30 times more protein than is present in the normal aqueous. It takes from seven to eleven days for the protein content of the aqueous to return to normal after paracentesis.

Another phenomenon which consistently occurs after paracentesis in non-glaucomatous eyes is filling of the canal of Schlemm with blood. This blood disappears from the canal as soon as the intra-ocular pressure reaches a level of 15 mm. or thereabouts. Other reactive tissue changes take place after paracentesis, but have not been studied as thoroughly as those mentioned in the foregoing.

How does the glaucomatous eye respond to paracentesis? This question can not, of course, be answered summarily, each type of glaucoma showing a fairly characteristic response. Let us take as the first example the narrow-angle glaucoma which since the advent of gonioscopy has become a sharply defined entity, characterized macroscopically by shallowness of the anterior chamber and gonioscopically by narrowness of the entrance to the angle. The fundamental fact with regard to these eyes is the strict parallelism between patency or obstruction of the angle and the ocular tension. As long as the entrance to the angle is sufficiently wide to permit the passage of aqueous toward the trabecular area, the intra-ocular pressure remains normal. If the entrance to the angle becomes obstructed by crowding of the iris toward the periphery, by contraction of the ciliary muscle during accommodation, or by hyperemia of the ciliary body, the pressure begins to go up. Under the heading of narrow-angle glaucoma come the prodromal attacks, the acute congestive glaucoma, and some forms of chronic congestive and of non-congestive glaucoma of the older classification. Paracenteses done on such eyes at times when the intra-ocular pressure is normal produce an initial drop which is not as marked as in non-glaucomatous eyes, so that in some cases a positive tonometric reading is obtained immediately after complete emptying of the anterior chamber. The explanation for this phenomenon simply is that the anterior chamber in these cases represents such a small portion of the total volume of the globe that the removal of the chamber contents is insufficient to lower the pressure from 25 to below the tonometric range. If the intra-ocular pressure has been abnormally high before the paracentesis, the phenomenon of a residual tension after emptying of the chamber may be very marked. In eyes with tonometric readings of 80, the emptying of a chamber containing less than 0.1 cc. usually brings the pressure down only to 40 or 45 mm. The restoration time in such eyes is short and the hypertensive phase is usually

mild. The hypotensive phase does not appreciably differ from that of a non-glaucomatous eye.

At the Illinois Eye and Ear Infirmary I have known several surgeons who perform paracenteses as a temporizing procedure in the acute dramatic phase of narrow-angle glaucoma, known and dreaded under the name of "acute congestive glaucoma." I was surprised to see that Spaeth in his text on ocular surgery specifically recommends paracenteses for such situations. From our findings I believe that paracentesis in these cases is of no therapeutic value and may even aggravate the condition. The emptying of the chamber, whether it is brought about with a hypodermic needle or with a keratome, in most instances does not bring the pressure down to zero. The simple reason for this again is that in an eye whose ocular tension is in the neighborhood of 100 the removal of .05 or .075 cc. of fluid, which is all the anterior chamber contains in these cases, can not be expected to bring the pressure down to within normal limits. Besides, the small amount of fluid that has been removed is almost immediately regenerated and the pressure rises to the original high level. There is no hypotensive phase to speak of in such cases. In acute congestive glaucoma it should be the object of any surgical procedure to reopen the entrance into the angle. As far as I can see, paracenteses cannot be expected to accomplish this.

The second group of glaucomas which I wish to discuss here are the chronic simple, apparently primary, glaucomas in which gonioscopy reveals a wide open angle. The mechanism of this probably very heterogeneous group of wide-angle glaucomas is only very incompletely known. The initial drop of pressure after the paracentesis, as well as the restoration time, is usually of the same magnitude as in non-glaucomatous eyes. I believe that a very pronounced hypertensive phase is characteristic of wide-angle glaucomas. In a series of fifteen eyes showing early stages of wide-angle glaucoma the hypertensive phase was in every instance more pronounced than in any of the non-glaucomatous eyes. Tonometric readings of 50, 55 or 65 mm. are quite common during the hypertensive phase of eyes with wide-angle glaucoma. The hypotensive phase after paracentesis in wide-angle glaucoma is hardly ever demonstrable. Therefore, I believe that in wide-angle glaucoma paracentesis is of no therapeutic value, not even as a temporizing measure.

There is a third form of glaucoma in which paracentesis is of no value, and that is the glaucoma secondary to obstruction of the central retinal vein. Immediately following paracentesis on two such cases at which I had the opportunity of being an innocent bystander, the anterior chamber became completely filled with blood. Apparently the newly-formed blood vessels in the chamber angle, the presence of which has been revealed by pathological studies, are very apt to rupture during a sudden decompression such as is entailed in keratome in-

cisions. Both patients became much more uncomfortable after these paracenteses and I believe that nothing whatsoever was gained.

Now let me turn to the glaucomas secondary to uveitis in which, excepting cases of iris bombée, paracentesis has a great deal to offer and is therefore definitely indicated when conservative measures have failed. You all remember the series of cases of uveitis with secondary glaucoma which F. B. Fralick and his associates presented at the last meeting of the American Academy of Ophthalmology and Otolaryngology. I had been asked to discuss the paper and had to disagree with only one thing in his paper, namely, the use of the word "only" in the following sentence: "Paracentesis was performed in 58 eyes showing some degree of active uveitis. We were surprised to find that in only 25 eyes (43 per cent) normal tension was obtained without more radical surgery." Does such a percentage of successes in a procedure as simple and harmless as paracentesis justify the use of the word "only," if a much more radical procedure like a trephine was successful in 60 per cent? I truly believe that paracentesis made a good showing in Dr. Fralick's series. I have found that cases of glaucoma secondary to uveitis respond to paracentesis with no or only very slight hypertensive reaction which is followed by a very definite hypotensive phase. Even if no permanent relief is obtained, paracentesis serves as an effective temporizing measure, producing a relative hypotony of from two to five days. I have found it impossible to predict from the gonioscopic, as well as from the clinical, picture how long this hypotensive phase is going to last and whether or not the patient will derive any permanent benefit from the paracentesis. While it is true that we are seeing more and more definite improvements of the clinical condition after paracentesis in anterior uveitis, we have the feeling that we are still groping in darkness with regard to when these paracenteses are most indicated. The question arises how often should the paracentesis be repeated in a given case of uveitis? Fralick's series give a definite answer to this question.

TABLE I

Frequency of Paracenteses	1	2	3	4	5	6	7	8	9	Total
Tension Normal	19	2	3	1						25
Tension Elevated	7	15	3	4		3				33
Total	26	17	6	5		3				58

Surgical treatment of primary iridocyclitis with secondary glaucoma (from F. B. Fralick and associates, *Trans. Am. Acad. of Ophth. and Otolar.* 92, 1942).

Fralick's conclusion is, "If paracentesis is to be successful, one or two paracenteses at the most are usually sufficient, and after failure of paracentesis on two occasions some other procedure might better be utilized unless the eye shows active inflammatory changes contra-indicating other surgery."

Since there is a possibility of a second or perhaps even a third paracentesis becoming advisable in anterior uveitis, I believe the first paracentesis

should be done with a narrow keratome, which will greatly facilitate further taps of the chamber. The sum total of pain will be less since the second or third emptying of the chamber can be done by introducing a spatula between the wound lips without grasping the conjunctiva or sclera with forceps.

Just how paracenteses exert their unquestionably beneficial effect in eyes with anterior uveitis is not entirely clear to me. I doubt very much that their main action consists of removing material which has clogged up the angle or the trabeculum. In my experience at least, paracenteses with or without exerting suction toward the end have been equally successful. Since a paracentesis of the latter type is more likely to remove blockage from the angle than a simple release of the aqueous without suction, I don't believe that removal of cellular debris from the inner surface or from within the trabeculum is an important factor in the success of the paracentesis. I also fail to see how the removal of the inflammatory proteins could act as the pressure-reducing principle since a large amount of new plasma proteins enters the anterior chamber immediately after the paracentesis. It is, however, possible that the inflammatory proteins become denatured after a stay in the chamber of several days and that their removal entails an anti-inflammatory principle. In many of the successful paracenteses the beneficial effect may have been due to the breaking of a vicious circle.

Paracenteses are used in ophthalmology to bring about a state of hypotony in cases in which the intraocular pressure was not abnormally high. Under this heading come the paracenteses used in progressive ulcerative keratitis. Again I do not believe that I completely understand how hypotony effects the rapid turn for the better in the course of such ulcers. In talking to my associates and students, I have made the statement that, "The cornea becomes unrelaxed after paracentesis." In a recent paper (*Trans. Am. Ophth. Soc.* 39:276, 1941) Sanford R. Gifford, the main advocate of delimiting keratotomy, has stated that the beneficial effect of the latter procedure is largely that entailed in an ordinary paracentesis. It is not generally known that if the chamber is emptied it is largely the cornea that assumes a new position and a new (less acutely curved) shape. In order to be beneficial in progressive ulcerative keratitis, the state of hypotony has to be maintained until the bacterial activity has come to a standstill. Thus daily paracenteses may be indicated for periods up to three weeks. Obviously this is done more conveniently if the original incision has been on the order of a keratotomy, that is, an incision made at right angles to the corneal surface. Such an incision can be reopened easily either by introducing a Darling cystotome or an iris repositor between the wound lips. Fistulation through such incisions, that is, seepage of regenerated aqueous through the incision, and the marked hyperemia with rapid reformation of aqueous which takes place in an eye treated in such fashion are in all probability bene-

ficial factors, but I believe that the hypotony is the most important therapeutic principle.

We all see, fortunately not too often, cases of non-suppurative, non-necrotizing, non-syphilitic, deep keratitis in which the etiological factor can not be established. After removal of all foci of infection which we can lay our hands on, after several courses of foreign protein therapy, and after administering what treatment with autogenous vaccine may seem indicated, we are at our wits end and have to confine ourselves to symptomatic therapy. In four such cases, after having been a bystander for several months while the keratitis continued with slight or moderate activity, I finally resorted to courses of daily paracenteses for periods of from six to ten days. In each of these cases my associates and I agreed that within two or three weeks after this rather drastic treatment the keratitis became inactive and the infiltrations were transformed into scars. It appears highly probable to us that the paracenteses in these cases brought about the termination of the keratitis.

As the last indication for paracentesis, we have mentioned in the beginning the temporary removal of the blood-aqueous barrier. This principle may have been active in some of the clinical conditions mentioned in the foregoing, in chronic uveitis, and in ulcerative and non-ulcerative keratitis. I believe that there are phases in chronic anterior uveitis in which paracenteses are indicated because of their barrier-removing value and not because of their effect on the intra-ocular pressure. I am thinking here of chronic iridocyclitis without ciliary injection, with no or only very slight increase in the protein content of the aqueous, but with very stubborn corneal precipitates which show no tendency to be absorbed. If all measures directed against the etiology and all the usual local measures do not bring about any change in the clinical appearance of the eye over periods of several months, I believe one or two paracenteses are indicated. They often bring about a striking immediate improvement in the clinical appearance of the eye in question. Besides, observation of such cases over periods of several years has shown that

these eyes do better in general during the six or eight months following paracentesis treatment. I have never seen an unfavorable response to paracentesis in such eyes.

Occasionally one sees cases of uveitis in which on first glance paracentesis seems to have had an unfavorable effect. I am thinking here of a case of a male patient, aged fifty-seven, who, when first seen at the Illinois Eye and Ear Infirmary, complained of inflammation and sudden loss of vision in his left eye following exposure to draft at his new place of employment. Examination revealed a bilateral chronic uveitis of long standing, which in the left eye was associated with secondary glaucoma. In this eye the cornea was steamy, there were extensive posterior synechiae and innumerable corneal precipitates; the eye ground was not visible; the vision was recorded to be finger-counting at one foot, and the intra-ocular pressure varied between 40 and 60, refractory to conservative therapy. Very extensive neo-vascularization of the iris was also noted. The patient complained of severe pain which was partly relieved by the usual analgesics. After a week of conservative therapy one of the surgeons performed a paracentesis with the keratome after which the entire anterior chamber became filled with blood. The intra-ocular pressure remained elevated, the pain persisted, and the hemorrhage failed to absorb. After six weeks an orange-yellow mass developed in the anterior chamber (xanthomatosis bulbi), the vision was lost completely, and because of the persistent pain the eye was enucleated. I do not believe that the unfortunate outcome could be chalked against the paracentesis because any chamber-opening operation would have been just as likely to lead to a severe hemorrhage which could not be absorbed on account of a membrane that covered the iris. A paracentesis with a hypodermic needle might not have led to as severe a hemorrhage into the chamber, but the ultimate outcome would probably have been the same.

In summary, I might say that paracentesis of the anterior chamber is definitely contraindicated in certain ophthalmological situations, is of no value in others, but is of definite benefit in certain forms or phases of uveitis and keratitis.

ABSTRACT

IMPROVED TYPHUS VACCINE REDUCES DEATH RATE AMONG THE AGED

Improvement in typhus vaccine has reduced the death rate from that disease in areas where typhus has been prevalent from 100 per cent to 50 per cent among people older than sixty years, *The Journal of the American Medical Association* for February 19 points out. Discussing recently issued reports on the typhus epidemic that swept Spain from 1939 through most of 1942, *The Journal* says that "the condition was fatal among all people older than sixty years." When strict control measures were placed in effect, including the use of several vaccines, one of the authors of the report on the epidemic

says that the modified Laigret vaccine helped bring new outbreaks of typhus under control in from thirteen to eighteen days, reduced the severity of the disease in vaccinated persons and improved the prognosis of patients older than sixty years with a 50 per cent survival among the vaccinated.

The Journal also says that "By use of vaccination, the new 'louse powder' and efficient delousing, typhus has been controlled in our Army and Navy. Epidemic typhus has not appeared among our troops in this war."

THE USE OF OCTOFOLLIN IN CONDITIONS OF ESTROGEN DEFICIENCIES AND IN GONORRHEAL VULVOVAGINITIS*

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It is the belief of the writer that one of the responsibilities of the practicing physician is the conscientious endeavor to find better methods of therapy, and it is particularly weighty when good facilities for gathering clinical data are available. Under such conditions a report of clinical results should be made. It is the privilege of the writer to have at his disposal a considerable number of patients in the gynecological service of the Indianapolis City Hospital and Indianapolis Isolation Hospital, as well as a goodly number of private patients. In this clinic group are included female children having "gonorrheal vaginitis" or "gonorrheal vulvovaginitis," and the usual number of menopausal and post-menopausal women and patients with various menstrual disorders.

As to the value of estrogen therapy in these various conditions there is little doubt. There is, however, a continual search for better estrogenic substances. The standard for judging such estrogens is threefold: clinical effectiveness by parenteral and oral routes, incidence of toxicities or side reactions, and lastly, cost of the medication. The natural estrogenic hormones, used either in the form of purified mixed estrogens or as esters of estradiol are clinically effective by parenteral routes of administration, and they show no toxicity at therapeutic levels. However, the oral-parenteral ratio of effectiveness is very high, about 20:1, and the cost of the material is substantial—particularly if it is desired to give it orally in effective dosage. Following the report of Dodds, Lawson and Noble¹ in 1938 a great interest arose in the synthetic estrogen diethylstilbestrol. This compound is an effective estrogen, almost as efficient by mouth as by injection, and its cost is low. However, a considerable volume of literature has accumulated indicating a relatively high incidence of untoward side reactions or toxicities—nausea, vomiting, dizziness and headache—following the use of diethylstilbestrol. This literature has been summarized recently by Morrell (1941)² and by the Council on Pharmacy and Chemistry (1942).³ The toxic reactions, while apparently not serious, have cer-

tainly been a factor in limiting the use of this estrogen in many instances.

Under the circumstances outlined it was to be expected that an effort would be made to develop a synthetic estrogen having the advantages of stilbestrol—low cost and oral activity—without the side reaction. For the last year and a half I have been using in my private and clinic practice a new synthetic estrogenic substance, octofollin. Reports of the clinical activity of this estrogen (then called 118B) were made in 1942 by Freed⁴ and his colleagues, and by Greenhill.⁵ The use of this compound in the treatment of "gonorrheal vaginitis" in children has been mentioned by the writer and his colleagues, Drs. Moenning and Bowman,⁶ in a recent publication (1943). Murphy⁷ has reported satisfactory clinical results with octofollin in the relief of the menopause, in gonorrheal vaginitis, and in the suppression of lactation (1943). Hufford⁸ and Roberts, Loeffel and MacBryde⁹ reported favorable results with this estrogen by both parenteral and oral administration. The development of this estrogen and the physiological work indicating its efficacy and safety have been outlined by Blanchard and his colleagues (1942, 1943).^{10, 11, 12} Our clinical results, which have been excellent, are reported here.

Clinical Material, Results and Discussion

Octofollin has been used in three dosage forms: in sesame oil for parenteral administration (5.0 mg. per cc.), in the form of tablets of 0.5, 1.0, 2.0 and 5.0 mgs. each, and in the form of small suppositories, containing 1.0 mg., for the local treatment of gonorrheal vaginitis in children.

* Freed, S. C.; Eislin, W. M., and Greenhill, J. P.: Assay in the Human Female of Synthetic Estrogen 118B; *Jour. Clin. Endocrin.*, **2**:213, 1942.

⁵ Greenhill, J. P.: The Use and Potency of Synthetic Estrogens, *Am. Jour. Obs. Gynec.*, **44**:475, 1942.

⁶ Jaeger, A. S.; Moenning, M. P., and Bowman, G. W., Gonorrheal Vaginitis, *Urol. Cutan. Revs.*, **77**:81, 1943.

⁷ Murphy, J. A.: On the Employment of Octofollin for the Relief of Menopausal Symptoms, for the Suppression of Lactation, and in Gonorrheal Vaginitis, *Am. Jour. Obs. Gynec.*, **46**:146, 1943.

⁸ Hufford, A. R.: The Synthetic Estrogen Octofollin (in oil), *J. A. M. A.*, **123**:259, 1943.

⁹ Roberts, H. K.; Loeffel, E., and MacBryde, C. M.: Octofollin. A New Synthetic Estrogen, *J. A. M. A.*, **123**:261, 1943.

¹⁰ Blanchard, E. W.: Responses of Laboratory Animals to a New Synthetic Estrogen, *Endocrin.*, **30**:1026, 1942.

¹¹ Stellbins, R. B., and Blanchard, E. W.: Changes in the Peripheral Blood and Bone Marrow of Rats Treated with a New Synthetic Estrogen, *Endocrin.*, **30**:1041, 1942.

¹² Blanchard, E. W.; Stuart, A. H., and Tallman, R. C.: Studies on a New Series of Synthetic Estrogens, *Endocrin.*, **32**:307, 1943.

* Octofollin, 2, 4 - di (para-hydroxyphenyl)-3-ethyl hexane, is a synthetic estrogen now on the market.

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¹ Dodds, E. C.; Goldberg, L.; Lawson, W., and Robinson, R.: Estrogenic Activity of Certain Synthetic Compounds; *Nature*, London **141**:247, 1938.

² Morell, J. A.: Summary of Some Clinical Reports on Stilbestrol, *Jour. Clin. Endocrin.*, **1**:419, 1941.

³ Council of Pharmacy and Chemistry: Report on Diethylstilbestrol, *J. A. M. A.*, **119**:632, 1942.

In the classification of endocrine disorders the existence of pluriglandular dysfunctions has been recognized by all clinicians. It is the opinion of the writer, however, that because of the close relationship between the several endocrine glands—either directly or through the pituitary—a true uniglandular dysfunction rarely exists. Therefore it has been his custom to treat the majority of menopause patients, and those exhibiting menstrual disorders, with desiccated thyroid (unless contraindicated) and other hormones when indicated, as well as with estrogens. The dosage of thyroid varies with the clinical needs of the patient and may be from 0.1 gr. to 3.0 grs. once or more often daily. In several of the patients octofollin was used alone, and in these considerable relief was reported. The dosage level under these conditions was comparatively high—about 5 mg. per day. When the estrogen therapy was supplemented by thyroid, as outlined above, complete relief from the menopausal symptoms was obtained with much lower levels of estrogen therapy—about 1 to 2 mg. per day. Thyroid alone was not effective in relieving the symptoms. The same results were obtained when octofollin was administered parenterally. Less frequent injections were necessary and the patient reported an additional feeling of well being when thyroid was being given.

Table 1 shows the number and type of patient treated with octofollin from May, 1942, to March, 1943. It will be noticed that the group ordinarily spoken of as "menopausal" has been divided into several smaller groups. This would seem to be a logical classification inasmuch as the endocrine picture in a patient just passing through the natural climacteric would hardly be expected to be the same as that in a several years' post-menopausal patient who, after a considerable period of freedom from all symptoms, suddenly has a return of the menopausal distress.

TABLE 1

SUMMARY OF CASES TREATED WITH OCTOFOLLIN

Cases usually classed as "menopausal":	
Recent surgically-induced menopause	42
Active natural menopause	15
Recurrence of menopausal symptoms several years after oophorectomy in which there had been longer or shorter symptom-free periods	7
Recurrence of symptoms two to ten years following natural menopause, with several years of complete absence of symptoms	7
Recurrence of symptoms several years after x-ray treatment which had been followed by complete cessation of menses	2
Endocrine dysfunctions in women under forty years old, with no appreciable pelvic pathology, and in whom menopause could seemingly be ruled out:	
Menorrhagia	7
Various symptoms indicating pluriglandular dysfunctions—amenorrhea, irregularity, slight dysmenorrhea	15
Cases in which the predominating and major symptoms were severe headache, usually of the migraine type	8

Senile vaginitis: Severe vulvovaginal and anorectal pruritus	5
Acute mastitis: following weaning of infants, resulting in solid, painful breasts with usual symptoms	2
Gonorrheal vaginitis in children	30
Total number of patients treated with octofollin	140

(Except in the "migraine like" headache group, it was possible to compare the various groups treated with octofollin, with a group of about similar number, treated without octofollin.)

In discussing the results of therapy in the above cases it must be pointed out that the measure of clinical response was based largely on subjective findings with the exception, of course, of the cases of gonorrheal vaginitis. In a few instances vaginal smears were made but the results from such tests seemed to show little correlation with the clinical findings.

In no case was there the slightest symptom of nausea, vomiting, dizziness, headache, or any of the other untoward effects not infrequently reported with diethylstilbestrol. Many of these patients had had previous therapy with diethylstilbestrol, both orally and parenterally, with unpleasant symptoms.

The clinical results following octofollin therapy have been excellent. All of the seventy-three patients classed as "menopausal" obtained marked or complete relief of symptoms. The estrogen was given in tablet form, at daily levels of 1 to 5 mgs., or by deep intramuscular injection in sesame oil, 2 to 5 mgs., once, twice, or three times weekly. Most of these patients received thyroid as previously mentioned.

As might be expected, the clinical results with octofollin in the cases of menstrual disturbances, while uniformly satisfactory, were not one-hundred per cent perfect. Many of such dysfunctions are recognized as probably not being of endocrine origin and do not respond particularly well to estrogen therapy. Of the seven cases of menorrhagia, one patient was unimproved by a combination of hormonal therapy. The other six cases were regulated in from three to five months by using octofollin during the first, or proliferative, part of the menstrual cycle, and some luteal hormone, given orally or by injection, during the second phase of the cycle. The use of luteal hormone alone had given no results in the regulation of the menorrhagia.

Of the fifteen cases showing symptoms of various dysfunctions of pluriglandular origin, i.e., amenorrhea, irregularity, and slight dysmenorrhea, thirteen showed marked or complete improvement, and two showed little response. In many of these patients thyroid was used as a supplementary therapy.

It is with some hesitation that I am including in this report the eight cases in which the predominating and major symptom was severe headache of the migraine type. It is recognized that such symptoms may result from a variety of causes, and that under such conditions there should be no logical reason to suppose that estrogen

therapy would be effective in but a small number of the cases. The excellent results obtained with octofollin therapy in six of the eight cases treated are sufficiently striking to justify calling attention to them. In these six patients the migraine headaches were practically abolished and the patient's general condition greatly improved. Two patients showed no beneficial effects.

The results of the treatment of five cases of senile vaginitis are not striking. Two of the patients reported considerable improvement, although occasional recurrences of symptoms persisted. The other three showed some slight response to the estrogen therapy but received relief from the symptoms only with x-ray therapy.

Octofollin in doses of 5 to 10 mgs. four times a day has been used for the suppression of lactation with completely satisfactory results. As had been expected, no untoward response occurred.

At the time of writing, thirty children, ranging in age from a few months to ten years, have received octofollin as a part of the therapeutic regime for gonorrheal vaginitis. A full discussion of the method of handling these patients in the Gynecological Clinic of the Indianapolis City Hospital has been presented in a recent report by the writer and his co-workers (Jaeger, Moenning and Bowman, 1943).⁶ Since we do not believe that either estrons alone or sulfonamides alone cure many cases of gonorrhea in females, the octofollin was given with sulfonamides and local treatment. We have used the estrogen in tablet form, in small suppositories, and in small ellipsoid-shaped tablets designed especially for use as vaginal inserts. After using octofollin for the last eighteen months we believe that it is superior to stilbestrol as an estrogen in the treatment of gonorrheal vulvovaginitis. No side reactions have been seen. The resulting maturation of the vaginal mucosa occurred sooner than with diethylstilbestrol, and the first negative smears were obtained proportionally earlier. No instance of the development of secondary sex characteristics were encountered. The tablets, 1 mg. per day, or 1 mg. suppositories appeared to be equally efficacious, but the vaginal inserts seemed to be somewhat more effective—0.5 mg. inserts were apparently as therapeutically active as the 1.0 mg. suppositories.

Summary

During the last two years I have used the new synthetic estrogen, octofollin, in patients in whom estrogenic therapy was indicated. The results have been uniformly satisfactory. The material has been administered by mouth in daily doses of 1 to 10 mgs., in oil by intramuscular injection of 2 to 5 mgs. one to three times a week, and in $\frac{1}{2}$ or 1 mg. suppositories or tablet inserts daily or twice daily to children without a single case of nausea, vomiting, dizziness or any of the other side reactions reported as following diethylstilbestrol therapy. Many of the patients who were satisfactorily treated with octofollin were intolerant to the stilbestrol.

A better response was obtained with this estrogen when thyroid in varying amounts was used as supplemental therapy. This has been the experience of the writer in the administration of any estrogen, and serves to point out anew the pluriglandular nature of the great majority of endocrine dysfunctions.

The average daily dose of this estrogen when given orally, in conjunction with thyroid, was approximately 2 mg. In certain patients the omission of the thyroid raised the daily need for the estrogen to 5 mg. per day. When octofollin was given in oil the dose was 2-5 mg. once to three times a week, or less frequently after the symptoms were under control.

In my opinion octofollin is an excellent estrogenic agent and is to be preferred to diethylstilbestrol. It must be remembered that somewhat more of the material must be given, milligram for milligram, than stilbestrol, but at the therapeutic level this new estrogen exhibits no side reactions.

In the treatment of gonorrheal vaginitis in little girls, octofollin $\frac{1}{2}$ to 1 mg. per day, either parenterally in tablet form, or locally in suppositories, or vaginal inserts, produced a rapid maturation of the vaginal mucosa, and in conjunction with the sulfonamides and local therapy yields negative smears somewhat sooner than when the other estrogenic substances, natural or synthetic, were used.

430 BANKERS TRUST BUILDING

ABSTRACT: SAYS COLD VACCINE SALES UNWARRANTED COMMERCIAL ASSAULT ON PUBLIC PURSE

The prescription and sale of cold vaccines is an unwarranted commercial assault on the public pocketbook, *The Journal of the American Medical Association* for January 22 declares. *The Journal* says:

"Recent communications to the offices of the American Medical Association indicate that the prescription and sale of cold vaccines is again taking place on a large scale. This, in the face of the recognized lack of sci-

tific evidence for the value of these preparations, is indication of irresponsibility on the part of some manufacturers of pharmaceuticals. The scientific evidence against the value of oral cold vaccines is overwhelming; consequently individual physicians and firms who deal in pharmaceuticals and who lend themselves to wholesale uncontrolled distribution of such preparations are perpetrating an unwarranted commercial assault on the public pocketbook."

TECHNICAL IMPROVEMENTS AND A DECLINE IN POSTOPERATIVE MORTALITY*

CHARLES N. COMBS, M.D.

TERRE HAUTE

With a life-time of anesthesia behind me, I can well ask, What advance has been made? Is the process safer than before? The basic test of safety is the survival of the patient, and this paper is concerned only with the chances of his leaving the hospital alive after an operation under general anesthesia.

Every conscientious anesthetist prepares for each administration with the more or less subconscious prayer and hope that he will in no wise contribute to an unsuccessful result for the surgical operation at hand. To discover to what extent my personal supplications and aspirations had been realized, I reviewed 1,130 hospital post-operative deaths occurring in my records. As these departed spirits paraded before my attention, I heard them say in sepulchral tones, "What did you do to bring about my demise, or what did you fail to do that might have saved my life?" Admitting that this is a most lugubrious subject, we must face the issue squarely and add up the answers. Too often we attempt to escape like Rip Van Winkle with the excuse that this one doesn't count, and anyway it happens so rarely. Actually, the chances of survival are fairly good, for in my total series the gross mortality is 4.4 per cent. In a paper read in 1922 I noted a rate of 5.2 per cent to that date. In the last 5,000 operations the rate was 3.7 per cent, while the last 1,000 showed only 2.5 per cent. Certainly there has been a noticeable decrease comparing operations done under routine ether with operations done under the selective or combined repertory which we now have.

In some diseases various other factors determine the result more than the anesthesia. The data on appendicitis is particularly interesting. In the first one hundred cases (1903 to 1911) there were thirteen simple incisions for abscess, twenty-five appendectomies with drainage and only sixty-two clean cases. In the last one hundred cases (1942) there was but one incision for abscess, three drainage cases and ninety-six clean ones. Many of these latter would have required a drain except for the advent of the sulfa drugs. In the early series the mortality was 11 per cent, while in the last series, believe it or not, there were no deaths at all. Education has so molded public opinion that even a Christian Healer will hesitate to stay home and die with appendicitis. There is a strong desire to have a prophylactic appendectomy even at a financial sacrifice.

Taking up two major operations, cholecystectomy and subhysterectomy, my records disclose the fol-

lowing: removal of the gall bladder was performed 411 times under ether, in my earlier experience, with a mortality of 9.9 per cent, while 206 were performed under spinal anesthesia lately at a rate of 6.3 per cent. Removal of the uterus from 482 patients who were given ether, showed 4.0 per cent of deaths, while 330 recent hysterectomies done under spinal or cyclopropane had the low index of .6 per cent.

Statistics are dull enough, but in one hundred years from now, who knows but what this paper will be as amusing as a table I recently unearthed? In 1812 a study was made of 1,000 individuals in the New England states. Of these, 23 died at birth; 277 from cutting teeth, worms and convulsions; 80 from smallpox; 7 from measles; 8 from childbirth; 191 from consumption and complaints of the breast; 150 from fevers; 12 from apoplexy; 41 from dropsy; while 211 lived out the allotted three-score years and ten.

In delving deeper into the anesthesia influence, I tabulated the entire series of over 1,000 deaths under the following headings and sub-headings.

The outline I herewith present may be fairly accurate and apt as to the titles of the divisions, but I may be open to the charge of presumption in classifying the individual deaths under certain headings rather than under others. The human tendency is to attribute negligence to others rather to one's self.

A. Expected Deaths (722 or 64 per cent of the total)

1. *The inevitable end of the existing fatal disease for which the patient was operated.*—Five-hundred-forty-one deaths, representing half of the entire number. Of these, one-hundred-twenty-two were very late or really inoperable malignancies. Seventy-eight were neglected and septic appendix cases. Fifty-one were acute and infected gall-bladders. Thirty-five were prostate and bladder operations on old men with retention and damaged kidneys. The rest were major operations on sick patients—exceedingly poor risks, with last-resort surgery clearly indicated. There can be nothing else said except that these deaths were as unescapable as taxes.

2. *The expected conclusion of a mortal injury—*(115). Of these, thirty-three were laparotomies for serious abdominal injuries, eighteen were fractured hips in patients ranging from seventy years and up, eight were laminectomies, fifteen were decompression trephinations for fractured skulls—all years ago and rarely performed now.

3. *The result of a grave and to-be-anticipated complication peculiar to the disease or injury—*(63).

* Presented before the Section on Anesthesia of the Indiana State Medical Association, at Indianapolis, September 29, 1943.

For example, thirty-seven were from general peritonitis following appendectomy where the outcome would have been different except for the extension of the overwhelming infection. Nine were leakage and infection cases following gastrojejunostomy, a complication inherent in the prevailing technical method employed. Five were from septic meningitis common to the accident of opening the lateral sinus during a mastoidectomy.

4. *Incidental operation on a patient with a progressively fatal disease from which he ultimately dies*—One case only, a tonsillectomy done for mechanical obstruction on a small boy dying months later from Hodgkin's Disease.

B. Unexpected Deaths (130 or 11%)

1. *Pneumonia*—Twenty-one deaths; certainly too small a number. I can only surmise a larger number, suspected by the surgeon but not told to me or totally unrecognized either because masked by other symptoms or from failure to have roentgenologic examination. Hypostatic pneumonia is a very common terminus in bed-ridden patients, which if included would swell the list. The anesthetic factor is problematical as it is well established that if properly administered no one agent is more prone to cause it than any other. High abdominal surgery and upper peritonitis are the predisposing causes.

2. *Embolism*—Fifty catastrophic deaths occurring at the most inopportune time, just as the patient is ready to go home. I was surprised to find only six out of a total of 1,254 hernia operations, or one in every 200 operations. These stand out because of the stark tragedy ending the life of a healthy person. Most of the others were major operations involving serious pathology, especially suppurating conditions. Several followed fractures which may have been fat embolism. One notable exception was a simple perineorrhaphy.

3. *Uremia or acute urinary suppression*—Twenty-seven deaths, which certainly does not include a very large number, who had terminal renal insufficiency together with a general somatic disintegration. Many of these had a pre-existing nephritis which was quite properly ignored because of the urgency of the surgical intervention.

4. *Liver deaths*—Six examples are gall-bladder operations performed on a class of patients with assumed hepatic dysfunction inherent to the case. The acute cases die within the first thirty-six hours, with hyperpyrexia and coma—really never emerging from the anesthetic. The subacute cases die up to ten days following, of a combined hepatico-renal syndrome, for if the patient lives that long the liver toxins affect the renal cortex.

5. *Suppurative surgical parotiditis*—(5). Rare in clean cases and never lethal in my experience except in pus bellies, bearing out the conclusion that it is endogenous and not extraneous trauma.

6. *Acute gastric dilatation*—(9). It has been demonstrated that all general relaxing anesthetic

agents induce gastric atonicity. The extent depends not upon the agent but upon the degree and depth of anesthesia. Since ether can be pushed so easily, it ranks as a prime offender. The advent of spinal injection, together with earlier treatment by the Wangenstein method, have almost eliminated this as a cause of death.

7. *Diastasis or dehiscence of the abdominal wound*—(7). I have included every patient who died subsequent to a secondary closure irrespective of the gravity of the primary operation, as I felt that each one of them might have lived had this not shipwrecked the surgeon's last remaining hope.

8. *Paralytic ileus*—(7). From the dates on my records I would judge that this is an outmoded surgical alibi.

Having so far embraced 75 per cent of the total number in what we might term to surviving relatives as excusable or explainable disasters, we now approach the most delicate ground termed.

C. Presumably Avoidable Deaths (278 or 25%)

1. *Questionable or, more bluntly, wrong diagnosis*—(15). Without comment, may I enumerate them as a warning to would-be surgeons and as an admonition to all of us: four frank pneumonias in children operated on for appendicitis, likewise two typhoid ulcers, five exploratory laparotomies with no discernible pathology in the abdomen, but with what else no one knows as they were signed out as shock; one suspected pyloric stenosis, but with athrepsia; one appendectomy, but had meningitis with abdominal symptoms; one appendectomy, double salpingo-oophorectomy, and perineorrhaphy—discovering all too late that she had a perforated duodenal ulcer. One jejunostomy wherein the autopsy showed a syphilitic gumma probably amenable to treatment, but not surgical.

2. *Failure to properly evaluate the risk*—Thirty-four deaths, and perhaps this is being charitable. Predominating, of course, were sixteen cases of thyrotoxicosis in which the kind and length of operation was totally incompatible with the severity of the condition. There were also two appendectomies, one cholecystectomy and one amputation of the breast on patients with exophthalmic goiter wherein the surgeon wittingly or unwittingly elected to do another operation before rectifying a situation which would invariably flare up under undue stress. Eleven developed acute cardiac decompensation, and here it is up to the anesthetist to advise against anesthesia or to declare himself as to the probable result. Two were diabetics before the days of insulin. One was an asthmatic, but that is not necessarily fatal.

3. *Postoperative hemorrhage*—(15). Here again the dates are ancient, illustrating that by sad experience surgeons have become more meticulous as to hemostasis. Two thyroidectomies and four hysterectomies surely indicate early ineptitude. It must also be remembered that blood transfusion is

a comparatively recent procedure and most assuredly would have saved the life of the only tonsillectomy in my records, but that happened twenty-one years ago.

4. *Error in surgical technic*—(31). Embarrassment in the presence of my respected surgical colleagues prevents me from dwelling on this regrettable classification. I hope that my intimate notes on the original charts will not be revealed until the passing of this generation. Some of these were "gang" operations, of the most bizarre combinations you could imagine, as many as seven diverse operations on the same patient and consuming endless time. Many were inadvertently torn bowels and bladders, toward which I am lenient, having seen the best men do them. Such procedures as curettage on patients dying with puerperal sepsis, cesareans preceded by forceps and ligation of the femoral artery in a perineorrhaphy are not so easily condoned. By far the most hapless instance was the opening of the cecum in search of an appendix, and not even sewing it up.

Please do not associate this paragraph with any living surgeon, as I have covered a long period of time and many of the doctors have departed this life years ago. Also there was included work done by occasional or tentative operators, adorned temporarily with the title "surgeon."

5. *Error in anesthetic technic*—One patient only in my career died without benefit of any surgery. On a very busy morning in 1921 I too hastily sandwiched in what was to be a suprapubic cystostomy. After a few whiffs of nitrous oxide, he was extinct, leaving me with the consolation that on autopsy he was found to have a large aortic aneurysm filled with a white clot. A similar episode was barely avoided when the patient died on the cart just as she was being wheeled into the operating room. Two patients died of aspiration pneumonia, both drowned in stercoraceous vomitus while I was too surprised to lower the head of the table. Since then I have learned to use spinal or intratracheal anesthesia, or to keep a stomach tube in situ. Further indictment against myself comes under the next class denominated.

6. *Shock*—(172). Nine cases died on the table, of which six died during the operation and three after the operation was concluded but while remaining for artificial respiration and ineffectual treatment. Nine more died in bed within thirty minutes after reaching there. If you will accept my word for it, all but one of these were already in shock, practically moribund, and there was no element of surprise at the outcome. The exception was a patient with tubal pregnancy, and while the autopsy report absolved the anesthetist by giving hemorrhage as the cause of death, there was an unrelievable umbrage in the minds of the surgeon and the family. Sixty-six died within a few hours, sixty-one the next day, and twenty-six of delayed shock from two to four days later.

To boast that in this category the anesthetist had

little to do with the mortality would be only to proclaim that he was of little import and that his contribution as a member of the surgical team was inconsequential. Therefore, distasteful though it may be, I in no wise disclaim liability in deciding the patients' fate, for to do else would be to belittle my specialty. Shock is a canopy covering a multitude of sins, and a lot of these undoubtedly should have been placed under previously-mentioned categories. Many were done at the insistence of the relatives who, realizing that there was no hope without surgery, at least felt that action was better than inaction.

These one-hundred-seventy-two shock deaths would provide material for another paper if studied in the light of the recent questionnaire put out by the American Society's Committee for the Study of Anesthetic Mortality, or the most excellent and comprehensive syllabus made by Dr. George Thomas of Pittsburgh.

In sixteen early instances high abdominal surgery was done under ether with the surgeon insisting upon more and more relaxation in spite of the well-known fact that fourth plane ether causes irreversible changes in vascular tonus. Even though the anesthetist issued the warning, the surgeon legally did not have to obey and rarely did. Fortunately, that time has passed since the introduction of spinal anesthesia.

On twenty-six occasions injured patients with severe traumatic shock were subjected to surgery at a time when all they needed was shock treatment. Their sensibilities were so obtunded that my services were really unnecessary, and so I was *particeps criminis*. We all learned our lessons and in the past ten years such situations do not happen, thanks to the intravenous use of salines, plasma and blood. Both the surgeon and the anesthetist has a fielder's choice to make, and only the Great Scorekeeper can decide whether or not it is an error.

In my early use of spinal anesthesia I gave it to a few patients already in shock, under the erroneous impression that it would be easier on the patient. According to Dr. Beecher, spinal anesthesia, in interrupting vasomotor control breaks down an important defense against shock and Gordon-Taylor's conclusion is that "spinal anesthesia spells certain euthanasia for the shocked abdomen." If local anesthesia alone will not suffice, I prefer the judicious use of the short stimulating phases of ether, although in extra-abdominal surgery I incline to light pentothal supported by equal parts of nitrous oxide and oxygen. Of late years I have become a pentothal sodium enthusiast, but my sober judgment admonishes me not to use it where slight muscular movements are objectionable. An occasional grimace or a twitch of the foot is the best safeguard against danger—and the surgeon must understand this. I prefer that the surgeon be mad at me rather than to be afraid of me, although neither is necessary. On the other hand, if too light, laryngeal or pharyn-

geal reflexes may be stimulated and be greatly aggravated by any attempt to use an airway.

D. The Patients' Fault

Dedicated to five women whom our doctors vainly attempted to save after the uterus had been perforated by professional abortionists.

CONCLUSION

Looking back over forty years, it is evident that the selective use of newer technics is an improvement over the routine use of ether or even gas-ether, in spite of the fact that some clinics continue the latter method with satisfactory results to themselves.

Rather than pushing a single agent too far, it is better to use combined anesthesia. You can supplement with an auxiliary agent, as for example, local with pentothal, local or pentothal to piece out spinal, or nitrous oxide-oxygen with pentothal.

In high abdominal surgery the use of spinal anesthesia lessens the operative time by decreasing the technical and manipulative difficulties—a balance decidedly in favor of the patient. Less trauma conduces to fewer atelectatic conditions if we believe that it is pain that splints the diaphragm.

No doubt time and experience has resulted in better anesthesia no matter what type was given, and that adds to the significance of the adage that the administrator and not the agent is the prime factor. By the same token, the surgeons with whom I have worked have improved likewise in their surgical judgment, technical agility, and in their pre- and post-operative care.

It was only by the narrowest margin that the records escaped a larger number of anesthetic deaths. Under all agents I have had near fatalities. Danger lurks in any one of them, and many patients owed their lives to alert observation, prompt remedial measures, sweetened with a large portion of luck.

Finally, I regret to report that many of these conclusions are inadequately supported by factual evidence, for the percentage of autopsies on surgical cases average much less than those on medical cases.

DISCUSSION

GEORGE M. ROSENHEIMER, M.D., (South Bend): I have enjoyed Dr. Combs' paper very much, and since he has practiced anesthesia the number of years he has I do not feel qualified to discuss the paper. Nevertheless, a few years ago I became interested in my first two thousand anesthetics, so I went to work and investigated them. I was a little chagrined with some of the results. A few weeks ago I started to analyze my last two thousand, but I have not gotten very far. I am glad to say, however, that there has been a great improvement in the mortality and complications. Some of the improvement has been, I hope, from experience, and some from the newer improvements in the drugs we have used as anesthetic agents and the methods employed. As pointed out, the experience

of the anesthetist had a lot to do with it. I formerly dreaded having a gastric resection come for operation because we had a number of slow operators and invariably the patient went into partial or complete collapse. With the use of some of the newer agents, such as helium, gastric resection is just one of the ordinary cases that come to surgery.

As Dr. Combs pointed out, perhaps the reason for fewer complications is that the older surgeons are dead and the younger surgeons have become more experienced.

FLOYD T. ROMBERGER, M.D., (Lafayette): I wish to congratulate the essayist on this paper. It is seldom that I have heard anything as wholesomely educational as to have a man write frankly about what has happened to him. I think that any surgeon in the audience will agree that he as well as the anesthetist learn more by their mistakes and by a study of the things that happened to them than they do by their successes. I am sincere when I say that I think this is one of the most valuable papers that has ever been presented before this Section on Anesthesia since it has been started.

I would like to say, from my own experience, that I am not quite as apprehensive about this thing called "shock" with spinal anesthesia as the previous two speakers have emphasized. I do think that those of us who have made a study of it know that spinal anesthesia must be given with perhaps a little more caution, a little more skill, and certainly with less toxic doses and with a great deal more watchfulness.

Regarding cesarean section, it is not for me to question the reason why, but it does seem that more sections are performed than ten or twenty years ago. Beginning fifteen years ago when I first introduced spinal in our little town occasionally they would ask for spinal anesthesia for cesarean section. That subsequently became more frequent, and I do not believe that in the past year-and-a-half or two years a cesarean section has been performed in our town without spinal anesthesia. There were quite a number of them. I remember one occasion in the past few months when I administered spinal five times for cesarean section within sixty hours, from Friday morning until Sunday night. Spinal anesthesia in cesarean section, to me,—and I have given twenty-eight thousand anesthetics with my own hands—is one of the most beautiful and most life-saving procedures that I have ever seen in the operative field anywhere, and I have been in practically every large clinic from the northern border of the United States to the Mexican border, and from the Rocky Mountains to the east coast. The patients find it very acceptable, and the surgeons enjoy operating under spinal anesthesia in cesarean section. Maybe I am fortunate that men doing cesarean sections in my town, small as it is, are fast operators; they will do a classical section in twenty-two minutes and a low cervical very seldom exceeds forty-five minutes. You can procure anesthesia with a less toxic dose. It has been a very beautiful procedure.

Coming back to the subject of shock, maybe I do not recognize shock. Frequently surgeons will say, "I have a patient in shock." I do not know where you will find a case of more acute shock than in a patient who has a ruptured gastric ulcer and is operated upon forty-five minutes after rupture has taken place, or within two or three hours, because those patients are really in shock. I do not believe that in the last five years, in our little town, any patient was operated on for abdominal section for ruptured gastric ulcer who did not have spinal anesthesia. We do not use a very large or a toxic dose. We watch the patient very carefully, and I mean by that that we have been forced to abandon short-cut methods. I do not undertake to inject the agent for spinal and then go off to another patient. In the case of surgical shock, particularly in ruptured gastric ulcer, I never leave the patient's side, and I use my eyes and ears, as well as my fingers on the pulse, to catch any little change that might take place.

Again I wish to commend Dr. Combs for a very fine paper.

M. C. TOPPING, M.D., (Terre Haute): I did a

cesarean section once and Dr. Combs gave the anesthetic, which was ether. Immediately following the operation the patient developed a paralytic ileus, the abdomen became greatly distended, the bowel full of gas, and the uterus became large, soft and boggy and did not respond to any medication. A few hours later Dr. Combs came in and gave her a spinal anesthetic. Within a few minutes after the administration of the spinal the abdomen became flat; she passed large amounts of gas; the uterus contracted and became firm, and the patient was practically snatched from the brink of the grave. I think that is a pretty good example of the fact that spinal anesthesia does not interfere with the autonomic control of the uterus and bowel. I believe that is verification of the point made by Dr. Mueller a short time ago.

CHARLES N. COMBS, M.D., (Terre Haute) (closing): I had forgotten about the therapeutic use of spinal anesthesia. I would not guarantee that it always works that way, but it did in that instance. That case represents a complication we used to have frequently with the old classical operation under ether. The patient would develop ileus and sometimes pass out in spite of treatment.

CONGENITAL DILATATION OF THE PULMONARY ARTERY, WITH ERYTHREMIA

EMIL ROTHSTEIN, M.D.*

HUBERT B. PIRKLE, M.D.†

ROCKVILLE

Congenital dilatation of the pulmonary artery with erythremia is a very rare condition which is usually diagnosed only by x-ray or at postmortem. Its clinical significance is not great except that it may be mistaken for several other clinical entities, namely, pulmonary tuberculosis, rheumatic heart disease, polycythemia vera, or intrathoracic neoplasm.

CASE REPORT

M. B. H., female, unmarried, aged 47, was admitted to the Indiana State Sanatorium on June 19, 1942, with a history of hemoptysis and abnormal shadows found on x-ray examination.

After the diagnosis was established, her mother gave the following history of her infancy: Her birth was normal, but soon afterwards the mother noticed that the child's heart beat so vigorously that her crib seemed to shake. The vigorous pulsations would come on several times daily, in paroxysms, and would last for about one-half hour.

These paroxysms persisted with diminishing intensity for about eight weeks. From then on the patient was considered to be normal until November, 1940. At that time she had hemoptysis, and an x-ray soon afterward revealed some form of pathology.

This x-ray was subsequently seen by us and was substantially the same as the films taken in our institution. However, it was diagnosed at that time as mitral stenosis and pulmonary tuberculosis. She had no further symptoms until early in 1942 when a generalized feeling of "ill health" led her to seek admission here. On examination the skin was a dusky hue. The blood pressure was 120/80. The only cardiac finding was a well-marked accentuation of the pulmonary second sound. There was no adenopathy. The spleen and liver could not be palpated. The x-ray revealed a generalized marked enlargement of the pulmonary vessels and a marked enlargement of both hilar shadows. (Figs. I and II.) The cardiac shadow revealed enlargement to right and left with a marked accentuation of the pulmonary conus. There was a calcified plaque in the conus shadow.

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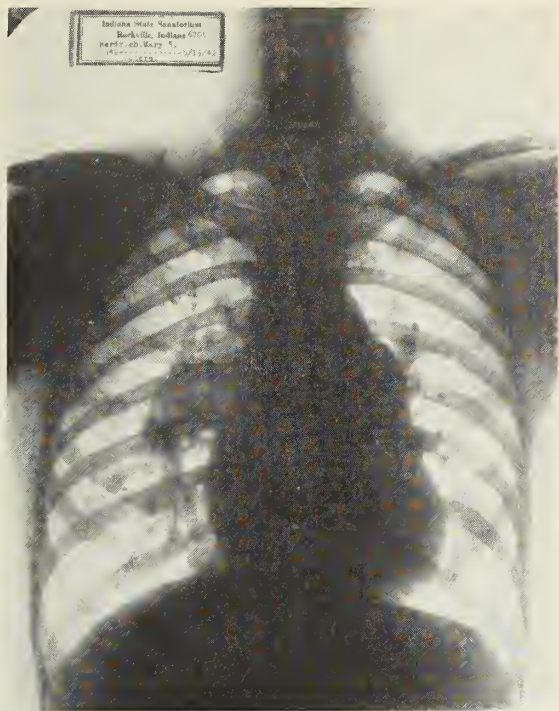


Figure I—P.A.

Fluoroscopic examination revealed that the enlargements in both hila pulsated freely and were due to enlargement of the right and left branches of the pulmonary artery. The enlargement of the pulmonary conus and artery were most marked in the right oblique position.

During her stay the following laboratory findings were noted:

Red blood count: 7,820,000.

Hemoglobin: 20.8 grams.

Hematocrit: 76 per cent.

Total blood volume (Congo Red Method): 4600 cc.

(Weight 97 pounds—volume per kilo 105 cc.)

Plasma volume: 1150 cc.

Red blood cell volume: 3450 cc.

White blood count: 6,750.

Sedimentation: 1 mm. in one hour.

Normal differential count.

Serology: Kline and Mazzini—negative.

Urine: Negative.

Numerous sputum examinations and gastric lavages were negative for tubercle bacilli.

The patient was discharged as non-tuberculous in July, 1942. About six weeks later she died at home without any symptomatic evidence of illness. No autopsy was performed.

DISCUSSION

Congenital dilatation of the pulmonary artery with erythremia is a rare condition. Kourilsky¹ states that only three cases were reported in the entire literature. Jennes² reviewed the literature

in 1936 and found only eleven cases in the previous literature with involvement of the main pulmonary artery and both its branches. The presence or absence of erythremia is not stated. Other similar cases have been reported by Oppenheimer,³ Przywara,⁴ Johnson.⁵ The presence of hemoptysis in our patient was probably due to the engorgement of the pulmonary vessels. It is probably impossible to make an exact interpretation of the attacks that were present during her first few months of life. The compensatory erythremia explains in part the absence of any cardiac symptoms. In spite of the enormously increased volume of red blood cells, the total blood volume was only moderately increased over the normal (105 cc. per kilogram of body weight, the normal being 85-90 cc. per kilo).

The etiology is stated in the literature as a congenital defect of the arterial wall or an unequal division of the truncus arteriosus communis. In a few cases other abnormalities are present which might have an etiologic relationship in increasing the minute volume of blood in the pulmonary artery, such as septal defects or patent ductus. In most cases, however, either no other anomaly is found or there is a hypoplastic aorta which is probably another manifestation of the same

² Jennes: *Bull. Johns Hopkins Hosp.*, **59**:133-142, (September) 1936.

³ Oppenheimer, B. S.: *Tr. Assoc. Am. Phys.*, **48**:290-297, 1933.

⁴ Przywara, L. E.: *Zeitschr. f. klin. Med.*, **128**:260-269, 1935.

⁵ Johnson, S. E.: *Ann. Int. Med.*, **10**:546, (October) 1936.

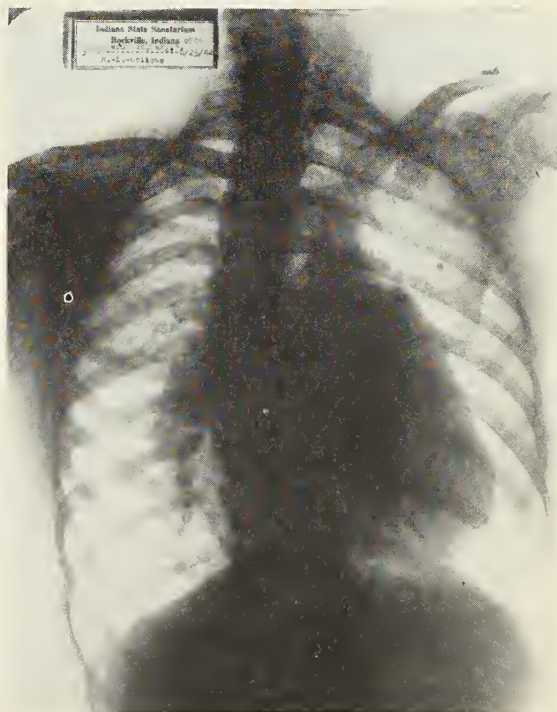


Figure II—Rt. Oblique.

¹ Kourilsky: *Bull. et mem. Soc. med. des hop. de Paris*, **56**:772-779, (Nov. 29) 1940.

anomaly. In our patient no definite evidence of any other cardiac lesion was detected. The arteriosclerotic plaque in the pulmonary conus was undoubtedly related to the prolonged increase in the intrapulmonary pressure.

Clinically, the lesion is relatively asymptomatic, most patients dying of other causes or developing cardiac decompensation late in life. As far as we can tell from the literature our case was the only one with blood volume studies. In polycythemia vera the hematocrit and red count are usually, but not always, above that found in our patient. However, the total volume is usually much greater (normal—85 cc./kilo—our case 105 cc./kilo—polycythemia vera 150-250 cc./kilo).

In polycythemia vera, where the count is often no higher, the blood volume is usually increased to a considerably greater degree.

Distinction between the tumor-like enlargement of the pulmonary arteries and true tumors, or Hodgkins disease, depends upon the fluoroscopic observation of clearly observed expansile pulsations readily visualized in our case.

SUMMARY

1. A case of congenital dilatation of the pulmonary artery and its branches, with erythremia, is presented.

2. The diagnosis depends upon observation by means of fluoroscopy of pulsatile hilar "tumors," plus a large pulmonary artery.

3. The condition may be mistaken for polycythemia vera, mitral stenosis, pulmonary tumors, and pulmonary tuberculosis.

4. The prognosis is usually good.

ERYTHROBLASTOSIS FETALIS*

GEORGE A. COLLETT, M.D.

WEMPLE DODDS, M.D.

ROBERT R. POLLOM, M.D.

CRAWFORDSVILLE

On January 20, 1942, Mrs. J. B., a white woman, aged twenty-eight, was delivered of what appeared to be a normal male child weighing 7 lb. 6 oz. She had had one pregnancy four years previously. This boy was living and well. Twenty-four hours postpartum the infant became jaundiced. This was rapidly followed by bleeding from the nose and mouth. Forty-eight hours after birth the white blood count was 25,900, red blood count 4.37 millions per cubic millimeter, and hemoglobin 72 per cent. There was no response to vitamin K therapy and hemorrhage became generalized from the mucous membranes. The jaundice became progressively more intense and death ensued on the sixth day. Examination at necropsy revealed little except enlargement of the liver and spleen. The microscopic examination of the various organs together with the study of the blood films led to a diagnosis of erythroblastosis fetalis.

About this time an article was published by Javert,¹ describing forty-seven cases and explaining the current concepts concerning the pathogenesis of the condition. Erythroblastosis fetalis, or acute hemolytic anemia of the newborn, are the terms used most commonly in the current literature. The

former term is preferred by many writers since anemia is in many cases not a prominent symptom. On the basis of the most prominent clinical features, Javert classifies his cases as follows: erythroblastosis with hydrops; erythroblastosis with icterus; erythroblastosis with anemia; erythroblastosis with hemorrhagic diathesis; and erythroblastosis without hydrops, icterus, anemia, or hemorrhagic diathesis. The presence in the blood of agglutinin Rh. was described by Landsteiner and Wiener² in 1940, and the relationship of this agglutinin to the development of erythroblastosis fetalis was pointed out by Levine, Katzin, and Burnham³ in 1941. If the father is Rh.+ and the mother is Rh.—, "the most likely explanation is that the infant being Rh.+ immunizes the mother against the Rh. factor by the transmission of the Rh. agglutinin, found in the fetal red blood cells, across a faulty-functioning placenta. Once the agglutinin gained entrance into the maternal circulation immunologic reaction is initiated and the mother forms an anti-Rh. iso-antibody, this iso-antibody then passes through the placenta to the fetus and hemolyzes the fetal red cells, resulting in the development of erythroblastosis."

Armed with this knowledge, we advised the par-

* Presented before the Section on Surgery of the Indiana State Medical Association at Indianapolis, September 29, 1943.

¹ Javert, Carl T.: Erythroblastosis Neonatorum—An Obstetrical-Pathological Study of Forty-seven Cases, *S. G. and O.*, 74: 1, (Jan.) 1942.

² Landsteiner, K., and Wiener, A. S.: *Proc. Soc. Exper. Biol. and Med.*, 43: 223, 1940.

³ Levine, P.; Katzin, E., and Burnham, L., *J.A.M.A.*, 116: 825, 1941.

ents against further pregnancy. Nevertheless, in the course of a few months the patient again became pregnant. About this time our attention was called to a report by Kariher and Spindler,⁴ in which the birth of an erythroblastotic infant was anticipated and its life saved by the transfusion of Rh.— blood. The father and mother were now tested, and, as was anticipated, the mother was Rh.— and the father Rh.+. The seriousness of the situation was explained to them and a search for a suitable donor for the unborn infant was instituted.

The infant was born May 7, 1943, approximately two weeks ahead of the anticipated delivery date. The child appeared healthy at birth, and weighed 7 lb. and 12 oz. Delivery was spontaneous. Three hours after birth a tinge of jaundice could be detected and the red blood count was 3.9 million per cubic millimeter, and hemoglobin 80 per cent. Unfortunately, because of the premature labor, only one Rh.— donor was available. We were aware that the most desirable donor would be a group O,Rh.— individual who had never received a blood transfusion or borne a child. Since we had just succeeded in obtaining Rh. testing serum and did not have a suitable group O,Rh.— donor available, it became necessary to use this donor. The donor's husband was Rh.+ and all three children were Rh.+, living and well. These facts made us still more reticent to use this donor, but since we were unable to demonstrate anti-Rh. antibodies in her serum, and since it had been fourteen years since her last pregnancy we thought it advisable to give the blood in the emergency.

Eight hours after birth the infant was given 100 cc. of citrated blood slowly through an ankle vein. Following this the general condition of the baby was greatly improved. The baby took its nourishment well, and twenty-four hours later the red blood count was 5.27 million per cubic millimeter, and the hemoglobin 85 per cent. No further transfusions were deemed necessary. The following morning the infant was listless. Its temperature was 103°, and it began vomiting. There was complete suppression of urine. Respiration became labored and death occurred approximately fifty-four hours following birth.

Necropsy showed findings identical to those of the other erythroblastotic infant. Study of the liver, spleen, and blood films showed the typical findings of erythroblastosis fetalis. Unfortunately, the placenta was not saved.

What are the lessons to be learned from this case? First of all, one can prognosticate with a high degree of certainty that when a mother has given birth to an erythroblastotic infant her next pregnancy will in a high percentage of cases result in the birth of another erythroblastotic infant. In rare instances where the father is heterozygous in

regard to the Rh. factor,⁵ his genotype being Rhrh, it is possible for Rh.— offspring to occur. However, the usual history is that the first child is normal but the second or third is erythroblastotic, and with each succeeding pregnancy fetal death occurs or the baby is born with erythroblastosis and dies within a few days.

It is interesting to speculate as to why none of the children of the donor in this case developed erythroblastosis. Her oldest child, a daughter, is nineteen; her second child, a son, is sixteen; and a third child, a son, is fourteen. There is no history of any disturbance during the pregnancy, and none of the children was jaundiced at birth. It must be assumed that the father was homozygous in regard to the Rh. factor, his genotype being Rhrh. Since the time intervals between the pregnancies were relatively short, this observation would indicate that not all children born of such parentage necessarily develop erythroblastosis.

The second lesson is that even though anti-Rh. agglutinins are not demonstrable in the mother's blood serum, the baby may develop erythroblastosis. This mother's serum was tested with Rh.+ cells from several individuals and no agglutinins were found, using a sensitive centrifuge technique. Furthermore, careful cross-matching tests between the bloods of the mother and baby revealed no incompatibility. That anti-Rh. iso-antibodies are not always present in the mother's serum is well-known. Wiener and Wexler⁶ have postulated the following: "As quickly as the iso-antibodies filter through the placenta they are taken up and stored by the fetal tissue cells. In that way their noxious action on the fetal erythrocytes is prevented at first. Only when the amount of iso-antibodies is so excessive that saturation of the tissues occurs do the antibodies combine with and destroy the fetal red cells. This may result in intra-uterine death. When the amount of antibodies is not excessive, the baby is born alive and the hemoglobin and red blood cell count may even be entirely normal at birth. After birth, for some reason that is not clear, the tissue cells release the Rh. antibodies which hemolyze the infant's erythrocytes. Accordingly, the severity of the disease in such cases depends upon the quantity of iso-antibodies stored in the tissues and upon the speed with which they are released."

We realize that our method of presenting this case is not entirely orthodox, but we thought it would be more interesting to narrate the history as it unfolded itself to us and to relate the various bits of knowledge with which we became acquainted during this study. It is for this reason that we have chosen this case. It has acquainted us with many new facts about conditions which were always unexplained to us in the past and, most of all perhaps, has impressed on us again the absolute neces-

⁴ Kariher, D. H., and Spindler, H. A.: Erythroblastosis Fetalis and the Blood Factor Rh., *Am. J. of Med. Sc.*, **205**: 369-376, (Mar.) 1943.

⁵ Wiener, A. S., and Wexler, I. B.: Transfusion Therapy of Acute Hemolytic Anemia of the Newborn, *Am. J. of Clin. Path.*, **13**: 393-401 (Aug.) 1943.

⁶ Kariher, D. H.: Erythroblastosis Fetalis Occurring in One of Twins, *J.A.M.A.*, **122**: 943-944 (July 31) 1943.

sity of careful correlation of facts learned in the laboratory and at the bedside. Even though our therapeutic efforts were of no avail, we feel that we have been well repaid because of the interesting and important knowledge acquired during the study of this case.

The foregoing case report is therefore not very important. However, it is important that the family doctor be able to give his patients such laboratory service as is here presented. It was very valuable for all concerned to be able to recognize the condition when the first baby died. It was extremely important to be able to prognosticate the course of events for the next pregnancy, in fact it reads like a fairy story. That we were unable to save the life of the baby was very disappointing, but it made us certain that there were other factors involved which could not be satisfactorily explained.

A pathologist and radiologist are considered a luxury in most small hospitals. Modern medicine requires them as an absolute necessity. This department renders a medical service and should be controlled by the medical staff. The laboratories should not be a source of revenue for the institution except to carry its own overhead. The one requirement for this department is accuracy. No sloppy technical work dare be tolerated. Eternal vigilance on the part of the director and the medical staff is necessary to minimize errors.

The laboratory does not make the diagnosis for you, but it may help you. "What does the blood count show, Doc?" should be answered by "nothing." A good library naturally follows in the wake of a good laboratory—one demands the other. Better medicine, less commercialism, less jealousy and more joy in the practice of medicine is found where accurate diagnostic work is attempted.

This case highlights the fact that modern medicine can no longer be practiced without the aid of expert laboratory service. This fact has not as yet been recognized by most county hospitals. In order for a hospital to function properly, it must be organized around the laboratories. The director should be a graduate in medicine. He becomes at once the daily consultant of the members of the staff. It is from this department that obscure symptoms are analyzed and the literature searched. It is from the examination of the pathological specimens, gross and microscopic, from cultures and smears, from blood studies and blood chemistry that light begins to dawn and therapy receives a rational basis.

Postgraduate courses are useless to a practitioner if he does not return to an institution where he can investigate his cases. With a resident pathologist and radiologist at hand, postgraduate work is a daily affair. Staff meetings become intensely interesting and always profitable.

A. S. GIORDANO, M.D. (South Bend): It is very refreshing to hear the speaker's kind remarks about the place of pathology in the practice of medicine. Those of us who have been engaged in the practice

of pathology in Indiana within the past ten years preach that gospel. We have as yet been unable to convince those who are responsible for the conduct of hospitals that they should see to it that men are attracted to the field of pathology, and men are not attracted to the field of pathology because the field has not been made very attractive. They are not treated as professional men in many instances, and their remuneration is very meager.

Going back to the report of cases, the discussion is very interesting. However, I should like to point out one thing, that the so-called "erythroblastic disease in newborn" does not necessarily have as its basis the Rh. factor. I think that later on, when a new serum is available, we will find the situation a little different. Recently I have had two cases of what we might call erythroblastic anemia, but in neither one of them did the Rh. factor play a part. The clinical picture, however, was that of erythroblastosis fetalis, so-called. Both the mother and the father were Rh. positive. The medical profession now is well aware of the situation.

Again I want to thank the speaker for his kind remarks on the place of pathology in the practice of medicine. It is well that the American Medical Association take a hand in this, and unless they do, the outlook is not good.

H. W. EGGERS, M.D. (Hammond): We recently have had about four cases. In the first three we knew definitely what to do, but they proceeded to die. The findings were not essentially the same as those discussed here, but we found a renal hemorrhage in all three cases. The last one occurred during the past year, in which the Rh. factor was definitely demonstrated. We found a donor and, starting the second day following delivery, we transfused this child directly with 100 cc.'s of blood every day for eight days. That was eight or nine months ago, and the child is now well.

I might say that the history of this family was typical in that we had two normal deliveries, then six normal deliveries, all of whom died at the end of the third or fourth day, and the ninth pregnancy (two normal deliveries and six dying with a diagnosis of erythroblastosis being made)—all demonstrated to have the Rh. factor.

F. B. MITMAN, M.D. (Huntington): I am at present faced with a situation such as this. I will discuss it briefly. The first pregnancy was taken care of by one of our men. Apparently the history was negative. The baby was normal at birth, but on the ninth day developed a gross appearance of blood from the bowel with vomiting, and died three days later. I had this patient a second time, with about the same picture except that it began on the eleventh day and death occurred on the fourteenth. I again delivered her three days ago. The first two were boys. The one delivered three days ago was a girl, perfectly normal—premature according to our figures, but apparently a full-term child. To date the baby is normal.

Unfortunately our county hospital does not have the services of a pathologist. I am wondering

since I have heard this paper, whether or not I am dealing with the same thing. I know nothing about the father's family. I do know about the mother's family. I delivered the mother about six times out of ten. She delivered one dead, premature eclamptic. The rest were normal. I have delivered three of her daughters of normal babies, and I have delivered the daughter-in-law of a normal baby. This time I gave her vitamin K routinely for three weeks. I gave her synkamin when she came into the hospital, and I gave her baby synkamin as soon as it was delivered, and this is the fourth day and so far the baby is normal.

The baby I delivered previously was not anemic when born; he was a perfectly healthy child. He was not icteric, and he nursed and gained normally in weight. As nearly as I could tell clinically, he was a perfectly normal baby until the eleventh day. I have no laboratory to fall back on, and I wonder what suggestion the doctor might give me in the way of procedure in the absence of laboratory findings.

E. S. JONES, M.D. (Hammond): The three cases that Dr. Eggers spoke about came to autopsy, and all of them contained hemorrhage into the suprarenal gland. I wonder if that is the report in the literature, Dr. Collett, that all cases have hemorrhage into the suprarenal glands?

GEORGE COLLETT, M.D. (Crawfordsville): I do not remember reading anything about the suprarenal in the cases that I reviewed for this paper, but I will make a confession because I am masquerading a little in treating this sort of thing. In fact, I am a general surgeon and I came into this picture because I was called in. The first baby was bleeding and jaundiced, and I saw it because it was sort of an emergency affair and Dr. Dodds was not available. I got into the second one on the transfusion. The family doctor was Dr. Pollom and the pathologist

was Dr. Dodds. We all worked this thing out together, as we do in a small community like ours where we try to dig out some of the things we do not know.

Now as to answering Dr. Mitman's question, I think if you would have the blood tested to see if she is Rh. negative or Rh. positive, it would give you the picture. You can send the blood to a laboratory. When we get into the Rh. figures you can toss them around a little and I do not know much about it, but I would refer you to a pathologist. Send the blood to any good laboratory, and if the mother is Rh. negative you can anticipate another erythroblastic infant. As I gather it, it may be any gradation, depending on how severe the immunization is, and certainly every woman who is Rh. negative does not have an erythroblastic child. There must be some defect in the placenta in some of them whereby the blood crosses the placental barrier. The donor apparently had a perfectly-functioning placenta and her children developed no immunity, or she developed immunity to the Rh. positive red cell.

DOCTOR EGGERS (Hammond): Dr. Davidsohn, at Mount Sinai Hospital, in Chicago, has done a lot of work on this Rh. grouping. I consulted him and at his suggestion we started on the second day with a transfusion every day, and he maintained that by doing this the child would by the end of about the tenth day ordinarily overcome this factor and get along of its own accord. He suggested a daily transfusion of at least 100 cc., starting the second day and stopping about the tenth, which we did, and then we watched the child very closely until the jaundice had disappeared and the blood count came up to normal. On the third day the count had dropped quite low and stayed low, but about the sixth day it gradually increased.

ABSTRACT

WARNS AGAINST THE INDISCRIMINATE USE OF SULFATHIAZOLE OINTMENTS

The indiscriminate use of sulfathiazole and other sulfonamide ointments "in minor conditions, when less harmful drugs are adequate, should be discontinued," Roy A. Darke, M.D., Assistant Surgeon, U. S. Public Health Service, New York, declares in *The Journal of the American Medical Association* for February 12. "With the widespread publicity being given to these preparations," he continues, "it would seem desirable to prevent or discourage their sale except by prescription."

Dr. Darke says that "the recent widespread use of sulfathiazole ointment has revealed cases of sulfathiazole sensitivity. My aim in this paper is to call attention to the degree of sensitivity to sulfathiazole ointment existing among the general population. . . ."

Reporting on a group of 218 patients who were treated topically with 5 per cent sulfathiazole ointment,

he says that sensitivity was found to be present in 12 cases (5.5 percent). This seems to be in approximate agreement with the findings reported by other investigators, both in the topical and oral administration of the drug.

The permanence of the sensitivity in Dr. Darke's group is not known, he says. The contact dermatitis in each case disappeared when the ointment was no longer applied. The healing of the condition being treated, however, seemed to have been definitely slowed.

"Because this sensitivity may preclude the use of the drug in the therapy of such diseases as meningitis, pneumonia and gonorrhea, it is important that sulfathiazole and other sulfonamide preparations be used topically only when a specific need for them can be justified," he advises.

SYMPATHETIC OPHTHALMIA*

H. C. WURSTER, M. D.

MISHAWAKA

I was prompted to select this subject because of the fact that only a few years ago at our State Academy meeting one of the essayists denounced the importance of sympathetic ophthalmia, particularly in cases of intra-ocular foreign body, and made one feel that such a condition scarcely existed, if at all, and got by with it.

By citing one case of sympathetic ophthalmia, with some discussion and review of the subject to date, it may serve to neutralize such an idea and create some interest even though it is an old subject.

With increased industrial activities, due to the war, and with many inexperienced workers, we all realize that there is a marked increase in the number of eye injuries. It reasonably follows that we as ophthalmologists are in turn expected to exercise every preventive measure possible to prevent blindness or loss of vision.

We, as well as the insurance companies, industrial safety directors, and other organizations have done a great deal in exerting pressure for safety measures and devices, but still there is one phase of the campaign or endeavor to preserve vision that we as ophthalmologists must be responsible for, and that is the prevention of sympathetic ophthalmia and its recognition with early and adequate treatment versus the unnecessary removal of eyes.

We all realize and perhaps agree that we see few cases of sympathetic ophthalmia, probably because of our enthusiasm to prevent it by early removal of questionable eyes. The practice of removing too many eyes too soon can be criticized just as well as the practice of allowing sympathetic ophthalmia to occur. The aim of this paper is to awaken interest in this problem and not to attempt to take sides or to make accusations.

It would be very desirable to know the actual number of cases of sympathetic ophthalmia which have occurred in the state of Indiana in the last twenty-five years, if all of the cases actually have been recognized, regardless of the manner in which it developed—whether from trauma, intra-ocular foreign body, infection, or surgery. It would be equally interesting, were it possible, to know the number of cases which were prevented. Even a voluntary report from every practicing ophthalmologist in Indiana, sent to the secretary of this section, would be appreciated, with the aim of a future announcement of such information.

The Army Medical Museum, through the kindness of Colonel Ash, informed me that out of 1,488

specimens of ophthalmic pathology, approximately 1,200 of which were enucleated eyes, received during the last fiscal year, five were cases of sympathetic ophthalmia. Of these 1,200 enucleated eyes one might wonder how many cases of this disease were prevented by this procedure itself.

So much for introductory remarks—the details of the case I wish to report are as follows:

F. K.—A young man, aged 17 years, while chopping wood with an ax about 3:00 P.M., on the afternoon of November 29, 1935, was struck in the left eye by a piece of wood. He immediately was attended by a certified ophthalmologist in a nearby city, who referred him to the hospital at once. The hospital record was not complete, but indicated that the patient had a laceration of the left lower lid and cornea of the left eye with a splinter of wood in the latter. The anterior chamber was described as being empty and open with lens substance and vitreous in the corneal wound. The vision of the left eye was limited to light perception only; the right eye was normal. The past history was uninforming. The left eye was operated about 7:00 P.M. the same day. Operative records stated that a small splinter of wood in the corneal wound was removed and a conjunctivoplasty done, apparently a Kuhnt flap. General physical examination was negative except for the injured eye and lid. Laboratory findings were: wbc., 7,350; Hb., 86 per cent; urine — 1 + alb. — Sp. Gr. 1.024 — 2 + pus; otherwise negative. The progress notes stated that the postoperative course was satisfactory and that the patient was released from the hospital on December 2, 1935, two and one-half days following his admission.

The patient stated that he reported daily or every other day at the office of the ophthalmologist for dressings. Then fourteen days after the operation, on December 12, 1935, he was admitted to the hospital for a second operation. The patient complained of considerable pain in and around the left eye. The physical examination record stated the lens was swollen, with ciliary injection and hypertension of the left eye. The hospital recorded a diagnosis of traumatic cataract and secondary glaucoma left eye—right eye still normal. A keratome incision was done, also an extraction of the lens with irrigation of the anterior chamber. Operative records stated that the corneal wound reopened by pressure of irrigation. Patient was released from the hospital the next day following the second operation, on December 13, 1935.

The patient's history from this point on was that his left eye became totally blind and that he was seen every day or every other day by the same ophthalmologist, at his office. Drops were put in

* Presented before the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association, at Indianapolis, September 29, 1943.

his eye. There was no great pain in the left eye and the right eye seemed normal. Then suddenly in two weeks after the second operation, or twenty-eight days after the injury, about December twenty-seventh, he noticed his right eye became involved. It became very sensitive to light and watered, but there was no pain. He noticed that close vision was satisfactory, but that distance vision blurred. He immediately was seen by the same ophthalmologist, who apparently took the visual fields of the right eye and referred him at once to another eye physician, also a certified man, who told him, according to the patient, that the left eye should have been removed long ago and that he had sympathetic ophthalmia. The patient then went to a third eye physician in the same city, quitting the first two, who also agreed with the diagnosis. Enucleation was done the next day on the left eye—the exciting eye. This eye was not sent to a pathologist for a section, but the patient was told that the enucleated eye was filled completely with pus. The vision in the right eye, the uninjured eye, failed rapidly and the patient reported that within two or three days from the onset of the trouble in the right eye the vision went out and he had to be led around. He received subcutaneous injections of some type and eye drops for the right eye, the remaining eye. Then in two or three weeks after the enucleation of the left eye he was told that he had a cataract in the right eye, and it also was operated by the third physician. No visual improvement resulted and he was told that nothing else could be done.

Then he sought further help and went to another eye physician, No. 4, in Michigan, who has a somewhat irregular reputation. This was in February, 1936. He was treated by him for about six months, until July, 1936, with drops. He stated that during this time he had pain and redness in the right eye, but no vision. Then he quit physician No. 4 and did nothing about treatment until November, 1936, when he was seen by another eye physician—this time in Chicago, a man who has a national reputation, who referred the patient back to physician No. 1. The record of physician No. 5, as given to me recently by him, described the case as follows: "Right eye—vision, fingers faintly at 3 feet, with light projection good. Moderate catarrhal conjunctivitis with some blebs at margin. Eyeball pale, but flushes easily upon manipulation. Tension—minus 1. Anterior cornea essentially normal. Post cornea plastered with K. P., some old and some fresh, sufficiently dense so that anterior chamber details are blurred. Slit lamp beam is visible in anterior chamber. Impossible to see cells. Iris very atrophic, extensive posterior adhesions, partially vascularized, lens completely opaque." He advised intensive therapy of sodium salicylates, calcium gluconate, atropine and diathermy, and referred him back to physician No. 1, as stated previously. A diagnosis of sympathetic ophthalmia was also made.

The patient returned to his home after having been seen by the prominent physician in Chicago, and refused to go back to physician No. 1. Nothing was done about any form of treatment until September 24, 1937, when I, physician No. 6, saw the patient for the first time. This was ten months after he had been to Chicago to see physician No. 5, or about one year and ten months after his original injury. The patient was a robust young man—now 18 years of age. He was led into my office by his young wife who was seven months pregnant. They asked and begged for help to restore at least some eyesight. This was a pathetic sight and one which made a lasting impression. My examination of the right eye revealed that it flushed easily on manipulation; tension — 1; slit lamp—right eye; large number of mutton fat; K. P. on posterior surface of cornea. Considerable fibrin, beam clearly visible in anterior chamber with a few occasional cells to be seen. Marked atrophy of iris. Nearly complete synechia. Vision—light projection only. My impression was that the patient had a sympathetic ophthalmia, and the patient was told that very little could be done for the eye.

The patient was referred back to physician No. 5, who recommended sodium salicylates in large doses, omnadin and heat. This advice was followed. The patient was again referred to physician No. 5, of Chicago, on March 8, 1938. His report: "Eye pale and flushes on manipulation; tension—2. The K. P. are absorbing and disappearing, but some remains are still present. Beam clearly visible. Still some cells in fairly active motion. Iris and lens practically unchanged."

An operation was advised by physician No. 5, of Chicago, April 9, 1938. Upon this physician's advice, I operated the right eye without much enthusiasm, as he had told the patient that perhaps he had a chance of one in a hundred for improved vision. It looked hopeless to me, for the right eye was already of subnormal intra-ocular tension with only the ability of light perception. A corneal conjunctival linear incision was made with much difficulty due to atrophy of the iris and adhesions, and an iridectomy was done. Adhesions and pupillary membrane were cut and lens material was removed by expression and irrigation. There was no vitreous loss. This was done April 19, 1938. Patient was released from the hospital on May 2, 1938. For the first few days I felt encouraged, but more adhesions formed and the pupil became obliterated.

The patient was again seen by physician No. 5, June 25, 1938. He reported a small Graefe incision right upper limbus with conjunctival vessels perforating at axis 10 and axis 90. These became lost in iris and lens, and cornea was moderately vascularized. Anterior chamber was very shallow, coloboma upward, filled with lens cortex. Tension —1. Advised heat, atropine and salicylates and further surgery. July 13, 1938, the patient was again operated upon by me. This was done with reluctance and certainly no enthusiasm. An attempt at removal of synechia was done with a keratome in-

cision, superiorly. This all seemed futile and later proved to be so. On July 19 the patient was released from the hospital. He still had light perception and some projection ability. In several weeks' time the reaction subsided and the eye became more soft and atrophic, and finally in several months even light perception was lost—ending in complete blindness—a tragic ending. The patient refused to have enucleation done. I hoped to get microscopic sections of the eye to verify the diagnosis of sympathetic ophthalmia, but I believe there should be no doubt as to the diagnosis, since each of the five other ophthalmologists were of the same opinion, proving that there are such things. Patient was last seen July 31, 1943, with a shrunken globe. He still refused enucleation. Incidentally, he was fairly well reconciled to the situation and not despondent, as he was several years previously.

A brief review of the subject of sympathetic ophthalmia might be timely and best done by quoting from several textbooks on the subject, and reference to current literature. Atkinson¹ in his book defines sympathetic ophthalmia as: "A number of pathological conditions occurring in a manner not thoroughly understood, as a result of inflammatory processes in a diseased or an injured eye, having involved the fellow or the previously sound eye. The greater percentage of such conditions are due to perforating injuries. They may, however, follow in the wake of a serious inflammatory or an infectious condition, such as corneal ulceration, uveitis or panophthalmitis. Sympathetic eye disease occurring as the result of injury may have been due to wounds in any part of the ocular structures, but the majority of them occurring in the literature have been secondary to wounds in close proximity to the ciliary region or have directly involved the ciliary body itself, in which more or less vitreous has been lost. Corneal wounds, in which no injury to the ciliary body has taken place, have seldom been followed by a sympathetic eye disease unless infection has occurred, ending in a purulent cyclitis or a panophthalmitis."

The etiology, in other words, is unknown, although there are numerous theories and explanations: first, the anaphylactic theory; second, the infective theory, but neither offer anything consistent or conclusive. The route of infection is still problematic. One explanation is that there probably is a selective affinity of a virus for the tissues of the uveal tract with direct transmission along the optic nerve and chiasm. Pathologic lesions have been demonstrated in the optic nerve 14 mm. behind the eyeball.

Berens² summarizes the etiology and states that neither the infection theory nor the anaphylactic theory explains the incidence of this disease. The truth may be in a combination of the two, a de-

veloping allergic pigment hypersensitivity predisposing the other eye to infection by noxious agents of unknown nature at the time.

Gill³ gives a most complete explanation of the mechanisms involved. He states that in certain cases of uveitis due to focal infection the severity of the uveal reaction is so great that the picture of sympathetic ophthalmia is strongly suggestive. These findings suggest that there is little if any essential pathologic difference in uveitis due to focal infection exhibiting uveal pigment hypersensitivity and sympathetic uveitis, except that of degree of pathologic change and the fact that there is usually, though not always, some type of traumatism associated with sympathetic uveitis. The reaction in sympathetic uveitis, as well as in the focal infection type, may be mild and easily controlled or fulminating and cyclonic in its course, resisting all therapy.

The difference in the mechanism of production in the two types is probably that a more rapid disintegration of uveal pigment takes place in injured eyes due to the occurrence of a greater number of leukocytes in the wound reaction, which act upon uveal pigment through their enzymes, converting the insoluble protein into a soluble substance which is absorbed and acts as an antigen, producing sensitization to this specific type of pigment similar to an Arthus phenomenon. Even though this type of pigment is found in other parts of the body, such as the central nervous system and in the internal ear, it has been demonstrated by Uhlenhuth⁴ and others that uveal pigment in its immunologic reactions is organ specific but not species specific.

Therefore, to explain why one individual with a perforating eye injury should develop a uveal pigment hypersensitivity and another with an apparently similar wound escapes it can be answered in part on the same basis as in other hypersensitive states.

In general, it may be said that cellular hypersensitivity may be inherited in varying degrees, from slight to marked, and that the degree of reactive capacity of the cells to a specific antigen is predestined in this manner. In another group of individuals susceptibility to the hypersensitive state may be brought about by alterations in the body chemistry, which in turn affect the permeability of cell walls of certain tissues.

Grimsdale and Brewerton's⁵ book on ophthalmic operations, in discussing sympathetic ophthalmia, emphasizes the problem of intra-ocular foreign body: "Until a few years ago it was taught that a foreign body of whatever kind, if left in an eye,

¹ Atkinson, Donald T.: *External Diseases of The Eye* (Copyright 1934, Lea and Febiger) Pages 510 to 515.

² Berens, Conrad: *The Eye and Its Diseases* (Copyright 1936, Saunders) Pages 683 to 686 and 733 to 744.

³ Gill, William D.: Read in Section on Ophthalmology and Otolaryngology, Southern Medical Association, Thirty-Third Annual Meeting, Memphis, Tennessee, November 21-24, 1939.

⁴ Uhlenhuth: *Festschrift Zum Sechsigsten Geburtstag Von Robert Koch*, Jena, 1903.

⁵ Grimsdale and Brewerton: *Ophthalmic Operations* (Copyright Wm. Wood & Co., 3rd Edition) Pages 118-120 and Pages 307-308.

would invariably produce sympathetic inflammation sooner or later. It is now known that this is erroneous, and that certain substances, such as glass and lead, may remain in the eye for years without producing any irritation; on the other hand, the presence of a piece of copper, which invariably produces intense chemical irritation, is frequently followed by sympathetic inflammation, particularly if the ciliary region has been injured. If a foreign body has been in an eye for two weeks and the eye remains in a state of general irritation, either the foreign body or the eye must be removed at once. The danger arises after the second week, to a maximum about the tenth week, and then slowly falls at the end of a year.

"One of the great disadvantages of delay is the fact that there are only two to three weeks of safety. If the surgeon wastes any part of this time, he increases the danger to the patient, and he will often feel bound to remove eyes that are not quiet because he dare not wait longer."

The latter authors⁵ emphasize the fact that there is evidence in the literature that sympathetic ophthalmia may occur after evisceration, but not after enucleation, meaning, of course, in cases where there is no pre-existing sympathetic ophthalmia.

Sympathetic ophthalmia has followed cases of sarcoma of the eye (choroid and ciliary body, et cetera), especially with perforation. There are also five authentic cases reported due to sarcoma and without injury or perforation of an eye.⁶

It is evident from the tragic nature of this disease that an early diagnosis is of considerable importance.

As to the diagnosis, Atkinson,¹ in his book states: "As an indication of the establishment of a sympathetic inflammation, symptoms of a simple irritation may or may not have been present. The condition has presented itself in numerous instances without any premonitory symptoms, often following an iritis of long standing or a penetrating wound of the eye, usually one in or near the region of the ciliary body, if a violent photophobia presents itself in the opposite eye. This, when accompanied by ciliary injection and diminished vision, or transient indistinctness of objects, lacrimation and tenderness of the eyeball, will point almost conclusively to sympathetic inflammation. The time at which such an inflammatory process is set up in the fellow eye is to be considered in making a diagnosis. DeSchweinitz gives the fourteenth day as the time in which sympathetic inflammation is most often established although, as he states, it has been known to occur as late as sixty years following the causative injury."

Berens,² in his book, quotes as follows: "The physical signs are those of slight ciliary injection, precipitates on the back of the cornea, vitreous opacities, and later all the clinical features of

iritocyclitis. The intra-ocular tension is raised in the early stages but may fall as the eyeball gradually shrinks. Secondary glaucoma may supervene as a complication. The course of the disease may take two or more years. With the slit lamp—floating cells in large quantities can be seen in the vitreous, aqueous and retrolental spaces and subsequently punctate keratic deposits are detected. Small transient patches of exudates on the pupillary margin and sometimes on the iris are recognized by the slit lamp in the early stages of sympathetic ophthalmia.

"Browning asserts that a differential blood count is of diagnostic value. He has brought forward evidence of an excess of large mononuclear lymphocytes, together with a concomitant decrease of polymorphonuclear leukocytes in sympathetic ophthalmia."

Some ophthalmologists, Elschnig, Woods, Knapp, and Gill, consider hypersensitiveness to uveal pigment, demonstrated by intradermal tests, to be pathognomonic of the condition. It has also been established by Dr. A. C. Woods that the blood serum of patients suffering from penetrating wounds of the eye react to complement-fixation tests, according to whether or not they developed signs of sympathetic ophthalmitis. Berens in his book states that intradermal tests with suspension of uveal pigment are not reliable in all cases, but a positive result is of diagnostic value.

The intracutaneous test to determine uveal pigment hypersensitiveness is performed by injecting approximately 0.25 cc. of normal tricesol free uveal pigment suspension intradermally and observing the reaction at the point of injection at intervals for twenty-four hours. A control injection is made with 1/20 dilution of beef serum. The so-called "normal uveal pigment testing solution" is made from the choroidal pigment from one beef-eye, suspended in 7.5 cc. of normal saline solution, and is free from preservatives, and great care is necessary in its preparation to insure absolute sterility. The therapeutic solution is made the same way, but with the addition of 0.5 per cent tricesol.

The pathology from the histologic viewpoint is first in the early stages a picture of nodular choroiditis with perivascular lymphocytic infiltration around the large- and medium-sized vessels of the choroid. At first the choriocapillaris remains free. Later this infiltration becomes diffuse, giant cells may be present, and there is some degeneration and heaping up of chromatophores. The vessels become sclerosed, and there is endothelial proliferation. The histologic appearance differs from those of tuberculous choroiditis in that there is no characteristic giant cell system nor areas of caseation, and extra-ocular extension does not occur.

There are instances of undoubted sympathetic ophthalmia, according to the literature, in which giant cells are not found in the greatly thickened uveal tract. The coulletes discarded prior to im-

⁶ Riwchun, Meyer H., and De Coursey, Elbert: *Archives of Ophthalmology*, 25:845-858 (May) 1941.

bedding the chief portion of the pathological specimens may contain the giant cells, or they may occur chiefly in the region of the vortex veins. Therefore, in doubtful cases these should be examined lest the characteristic cellular pathology be missed.

Last but not least, the therapy of this condition can be covered in part by quoting from Berens² text book, as follows: "Prophylactic treatment is directed toward immediate aseptic toilet of a perforating wound. Loose tags of tissue are excised, a foreign body removed, prolapsed uveal tissue excised, and care taken to see that no lens capsule or uvea is present in the wound before it is finally closed by suturing or by a conjunctival flap. Sometimes it is well to touch the lips of the wound with a little carbolic acid. The patient should be placed at rest in bed, atropine (1 per cent solution) instilled twice daily, and the injured eye kept closed with a pad and bandage.

"In cases where the eye is so severely damaged that it is improbable that useful vision will be restored, excision should be performed.

"When the eye is retained in the belief that useful vision may result, a careful observation should be made each day. If the inflammatory signs do not subside within a reasonable time, if ciliary injection persists and punctate deposits appear on the back of the cornea, the injured eye should be excised.

"The presence of a ciliary flush and a few keratic punctate deposits in the other eye is an indication for excision of the exciting eye.

"When sympathetic ophthalmitis is advanced in the sympathizing eye, it is better to retain both eyes, for often the exciting eye eventually has more vision than the other. The administration of sodium salicylate (40 gr. by rectum, t.i.d.), inunction of mercury and injections of neosalvarsan are of some value. The formation of a 'fixation abscess' by injecting 1 cc. of oil of turpentine, subcutaneously, into the flank has been advocated by Van Lint and Coppez.

"After some weeks or months have elapsed and all inflammation has subsided, optical iridectomy may be beneficial in selected cases. When the other eye is defective and the perception and projection of light are good and accurate, extraction of the lens after preliminary iridectomy is justifiable.

"Other therapeutic agents include injections of diphtheria anti-toxin, milk, autogenous serum, and arsenical compounds in large doses.

"Injections of a suspension of uveal pigment have been used for desensitizing those individuals who show hypersensitivity, and then for stimulating the formation of antibodies by active immunization. It may be that this procedure is equivalent to some form of nonspecific protein therapy." Other additional therapeutic agents have been recommended in the literature.

Gill³ states that uveal pigment suspension injected hypodermically is the most valuable single therapeutic agent to be used. After reading his

work everyone here should be inspired to try this form of therapy. He states that it is most effective if given intracutaneously because of the prompt response. The objection is that of having pigmented areas in the skin at the site of injection for a considerable time, but they disappear eventually. The initial dose recommended is 0.25 cc. and increase .25 cc. daily until 2 cc. is reached, and then it can be continued daily for three or four weeks if necessary. He has treated twelve cases with successful results, and he states that uveal pigment should be of value prophylactically, but he has had no experience with it.

The use of calcium, by mouth or intravenously, has been recommended with the idea that its use limits or reduces permeability of cell membranes and therefore lessens edema and exudation of the choroid. Similarly parathyroid extract, .5 cc. hypodermically, once daily, in conjunction with calcium is advocated.

Auto-hemotherapy is quite often of service. The method consists of removing from 2 to 5 cc. of whole blood from a vein of a patient and immediately reinjecting it intramuscularly. Daily administration is advisable. Its action is explained on the basis of a colloidoclasia, or splitting of the colloids, when blood escaped from the vascular system, these split products acting as foreign protein when re-injected.

With the same idea of building up immunity through foreign proteins, milk injections, omnadin or proteolac, et cetera, could be used. Gill³ advocates that the drug of choice for foreign protein effect, if one is sure the patient is nontuberculous, is tuberculin. It can be given in gradually ascending doses and injected daily, beginning with 1/100,000 dilution 0.1 cc., increasing by 0.1 cc. daily. Intracutaneous administration is preferable and old tuberculin has been the one of choice.

Sulfanilamide in small doses has been advocated, even as little as twenty grains daily, in all eye injury cases, and also in cases requiring intra-ocular surgery, for two days prior to and four or five days after. Gamble⁷ cited a proved case of sympathetic ophthalmia in which the patient died of another cause later—that the use of sulfanilamide did cause clinical improvement and normal vision was maintained for six months, at which time the patient died of injuries.

Bellows⁸ in a paper read before the American Academy of Ophthalmology on October 11, 1942, entitled "Chemotherapy in Ophthalmology," cited the previous mentioned case of Gamble, and also stated that Colenbrander reported an astonishing improvement in the sympathizing eye in a proved case of sympathetic ophthalmia treated with sulfapyridine and liver preparation. He also mentioned Gifford's six cases of sympathetic ophthalmia.

⁷ Gamble, R. C.: *Am. J. Ophthalm.*, **24**:49-51 (Jan.) 1941.

⁸ Bellows, John G.: *Arch. Ophthalm.*, **29**:888-903 (June) 1943.

mia, in four of which the disease responded well to sulfa therapy.

Obviously, local treatment to the eye is to be carried out along the usual well recognized line. Gill³ further advises that eradication of focal infections, or minimizing their effects when they cannot be completely eradicated, is urgently indicated early in the course of sympathetic ophthalmia, and when a focus is in any degree questionable, there should be no hesitancy to include it in the campaign of eradication.

Gill³ further states that eyes that have been the seat of sympathetic uveitis do not tolerate surgery well, and operative procedures on such eyes should be carried out only with the full realization of the reaction which may follow. This was well brought out in the case I cited.

Bellows⁸ states that penicillin, tyrothricin and similar substances obtained from moulds, fungi and bacteria, while not yet employed clinically in ophthalmology, give promise of future usefulness.

In conclusion, today the outlook for cases of sympathetic ophthalmia under the care of a competent ophthalmologist with modern therapy is emphatically better than it was twenty years ago, or even five years ago.

DISCUSSION

CHARLES GILLESPIE, M.D.: (Seymour) I have listened to Doctor Wurster's discussion of this subject with a good deal of interest and with much more interest than I would have a year ago. I have never treated a sympathetic ophthalmia for the reason, as the doctor mentioned, of early enucleation. When I see a perforating injury with complete and permanent loss of vision, that eye either comes out or someone else assumes responsibility. Perhaps I have removed eyes that might have been let alone,

certainly I have never left one in until sympathetic ophthalmia occurred.

This subject is more interesting to me now because I have been sitting on the side-lines watching two cases for the last six months. One was a boy thirteen years old with a perforating injury from a BB gun. This boy was taken to the hospital for about two weeks, and then the eye was enucleated. He developed sympathetic ophthalmia. He has been under treatment constantly from some of the best men in the country. The principal treatment has been large doses of sulfathiazole. It looked for awhile as if he might get along. A week ago he was taken out of school and put back on sulfathiazole. The remaining eye is irritated and visual acuity is very much reduced.

The other case was a perforating injury with a piece of steel. This was localized and removed within a few days of the injury. I have never seen the patient since, but I'm told that his visual acuity in the injured eye is reduced to light perception. About a month ago his wife was in my office for glasses and told me he was having considerable trouble with both eyes.

Nothing has happened yet to change my mind concerning the enucleation of perforated eyeballs with lost vision. There are some things that stand out in connection with this subject. One is that there is a period of irritation which lasts for a few days during which time enucleation is a safe procedure. Another is that the pathology in both eyes is identical. The theory of transmission has, of course, never been settled. I was taught that it was by way of the optic nerve through the chiasm, and to me this is still the most logical.

Dr. Wurster has given the different theories—you can take your choice.

ABSTRACTS

INHALANTS FOR INFLUENZA UNDESIRABLE

Use of inhalations of finely atomized specific antiserum for the prevention and treatment of influenza is not now desirable, *The Journal of the American Medical Association* for December 18 warns. It says that it has just been reported that serious reactions and death have occurred among animals being tested with such a procedure and that further human studies should be pursued with great caution.

A.M.A. COMMITTEE ACTS TO SOLVE PROBLEMS OF IMPROVED POSTWAR MEDICAL CARE

Three moves aimed at solving two of the most important problems in providing a better postwar distribution of medical care—a wider and more appropriate distribution of hospital and diagnostic facilities and an efficient means for providing for the location and relocation of physicians in the postwar period, have been made by the Committee on Postwar Medical Service of the American Medical Association, *The Journal of the Association* reports in its February 12 issue.

At a recent meeting of the Committee it was voted to recommend to the Board of Trustees of the Association that the Board look into the desirability of establishing an agency for disseminating information on the location or relocation of physicians in the postwar period.

The report points out that "Inasmuch as a wider and more appropriate distribution of hospital and diagnostic facilities would influence decisively a satisfactory location or relocation in the postwar period, the Subcommittee on Location and Relocation . . . was authorized to explore the subject of hospital and diagnostic facilities and the extension thereof as an effective measure in the better distribution of medical care."

In its third move the Committee authorized the sending out of a sample, or pilot, questionnaire of 3,000 copies to physicians in the armed forces. The purpose of the pilot questionnaire is to determine the best form of inquiry as to the probable nature of postwar needs of large numbers of physicians in military and governmental service.

**THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION**
DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

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MARCH, 1944

Editorials

THE SECRETARIES' CONFERENCE

The annual Secretaries' Conference for 1944 was a memorable one, and it probably will go down in our records as an outstanding success in a long list of notable achievements.

Much of the success of the conference may well be attributed to a new venture, a "School for Speakers" conducted at the morning session. This school was planned as a short, intensive course in the art of addressing lay audiences, the chief theme, of course, being the Wagner-Murray-Dingell Bill.

The speakers at this session were: Dr. Homer G. Hamer, chairman of the Bureau of Publicity; Mr. Clarence A. Jackson, vice-president and general manager of the Indiana State Chamber of Commerce; Dr. W. Norwood Brigrance, professor of Speech, Wabash College, Crawfordsville, and Dr. F. S. Crockett, of Lafayette.

These talks were all to the point and were designed to give the audience, composed of representatives from practically every county in the state, the proper approach to lay groups. Dr. Brigrance, in particular, proved to be a most interesting instructor. He dwelt on the fundamentals of speech-making, discussing phonation and enunciation—he even told how and when to use the hands and when to point the finger, not forgetting when to pound the table.

About two hundred Indiana physicians were present at the meeting, a large number being volunteers for a speaking campaign against any and all measures which would in any manner curb the medical profession.

The regular program of the conference was held in the afternoon. Dr. Charles N. Combs, Terre Haute, presented a comprehensive survey of "Hospital Plans in Indiana," this paper being discussed by Dr. L. Fernald Foster, secretary of the Michigan State Medical Society, and Mr. William J. Burns, the executive secretary.

Following this, Mr. John E. Farrell, executive secretary of the Rhode Island State Medical Association, discussed the "Health Insurance Program" of that state, together with a discussion of certain phases of "Public Relations in the New England States."

The "National Legislative Picture" was presented by Mr. J. W. Holloway, Jr., secretary of the Bureau of Legal Medicine and Legislation of the American Medical Association, while Dr. J. William Wright, of Indianapolis, discussed a similar subject, as applied to Indiana.

Later an open forum was held and numerous questions were presented from the floor. Dinner was served at the Indianapolis Athletic Club, with a large attendance.

Dr. J. T. Oliphant, president of the Indiana State Medical Association, was listed as one of the after-dinner speakers but was unable to be present because of illness.

Dr. Edward J. McCormick, of Toledo, Ohio, a member of the Council on Medical Service and Public Relations of the American Medical Association, gave an address on "Public Relations and the Medical Profession"—a most stirring presentation. Dr. McCormick, a former president of the Ohio State Medical Association, long has been a student of medical economics and is generally regarded as an authority on the subject. It was quite clear that he feels we have a big job ahead of us and that, while the lack is not insurmountable, it means we will have to take off our coats and do a real job.

Thus is sketchily presented the story of another achievement in Indiana Medicine; again did the Indiana State Medical Association score a big hit.

NATIONAL CONFERENCE ON MEDICAL SERVICE

The eighteenth annual meeting of the National Conference on Medical Service was held in Chicago on February thirteenth, with a large attendance considering weather conditions. With a winter storm of blizzard proportions, together with a sub-zero temperature, traffic conditions were such as to deter many who had planned to attend.

This is rather an out-of-the-ordinary medical conference, one in which the "open forum" method of handling medical problems is in vogue; one in which "all the girls let their hair down" and talk about anything that seems of current interest.

The program included several topics, "The Association of American Physicians and Surgeons"; "Proposals by the Medical Societies of New England"; "The Western Public Health League"; "Report from the Council on Medical Service and Public Relations"; "The Doctor's Job"; "Social and Economic Trends in Relation to Medical Practice"; "The Challenge to American Medicine"; "Digest of Recent Medical Legislation," and "Obstetric and Pediatric Care for Soldiers' Wives and Infants."

The above program gives some idea of the scope covered during the day, which, with a generous discussion of many of the papers, brought out a good cross section of American medical opinion.

Many of the speakers chose to talk in plain language rather than via the innuendo route. Criticisms frequently were heard because of the intransigent and irreconcilable attitude on the part of some of our leaders. This was particularly true during the discussion of the advisability of having a full-time bureau in Washington, many of the speakers being forthright in their pronouncements on this subject.

It was declared by several of the speakers that members of the Congress had suggested that this be done, one of the speakers being very vehement on this subject. Later in the meeting a resolution was adopted to the effect that the Council on Medical Service and Public Relations immediately take steps toward this end.

Other groups of professional men have such Washington bureaus and have found them exceedingly beneficial, so it was declared. Among these were mentioned the dentists, the American Hospital Association, the National Retail Druggists Association and, of course, the cultists.

Without doubt the outstanding feature of the program was the address by Walter H. Judd, Congressman from the Fifth Minnesota District. Dr. Judd is a physician with an unusual background. He served in a medical way for many years in China; he has practiced medicine for many years in his home state; he has had unusual opportunities of adjudging what is good medical service; and in Washington he has added to his large store of human experience.

Dr. Judd did not mince his words; he was most emphatic throughout his talk. He called things by their correct names, impressing his audience with the fact that here was common sense talk.

In speaking of the Wagner-Murray-Dingell Bill, he said: "This bill will not pass this Congress, but **THIS IS YOUR LAST CHANCE**," meaning that due to a concerted activity all over the country we had managed to arouse sufficient antagonism to the measure to insure its failure. But another day is coming; we dare not sit back on our haunches and say to ourselves: "Well, we done it," and be con-

tent. He means that the fight is just well under way and that any let-up will be our undoing. We trust that this talk may soon be available to the entire medical profession. As we have stated, it comes from a man "at the front," a man who from long and varied experience knows just what he is talking about.

The "Western Group" announced that as of March fifteenth they plan to open a Washington office of their own, financed and managed by some half-dozen state medical groups.

We have attended several of the meetings of this Conference, always coming away with the feeling that here is a group of men who are thinkers; men who are doing things; men with foresight. The recent session was no exception. If anything was different, it was the "we must do something, and at once" spirit.

It was patent, from one phase of the discussion, that American Medical Association leaders do not wholly agree with the spirit of such meetings, believing that the parent body is doing a swell job and needs no such prodding. However, it seems that many physicians are not wholly in accord with this dictum, preferring to hold such meetings as these where each one present may express his personal views.

INDIANA'S BASE HOSPITALS

During World War I a base hospital unit was organized in Indianapolis by Eli Lilly and Company and was designated as Base Hospital No. 32. The members of this unit saw service in France and so acquitted themselves as to become one of the outstanding groups of medical men in that war. They were accorded a full mead of praise by the commanding officers in charge of the American Expeditionary Forces and returned to this country at the close of the war with a full sense of accomplishment.

In 1942 another Indiana hospital group was organized, this time by the Indiana University School of Medicine. The induction ceremonies which took place on the campus of the medical center, in Indianapolis, remain one of the bright spots in a long list of notable events in Indiana Medicine.

The group was activated in March of 1943 and was sent to Camp Bowie, Texas, for final training, going overseas several months ago. The unit has been stationed somewhere in England since that time.

That this group, also known as Base Hospital No. 32, has lived up to the precedent set by its namesake is evidenced by a communication from Major General John C. H. Lee, commanding the service of supply for the United States Forces in the European Area, and Brigadier General Paul R. Hawley, chief surgeon of the same command. In this communication the hospital group is highly commended for its activities. We quote, "Never expecting less than the highest standards from the

Medical Corps, it is none the less gratifying to find things so well in hand." The statement also gives additional praise for the fine personnel and leadership of this organization.

This proves that even in the midst of a global war, where the commanding generals are inordinately busy with the details of that warfare, they find time to publicly praise where praise is merited.

We attended the induction ceremonies, many months ago, and were greatly impressed with the make-up of this organization. At the time we took occasion to remark, editorially, that Base Hospital No. 32 would be a credit to the organization of the same number in World War I, and our prediction has come true.

THE JOURNAL joins with Indiana Medicine in praising this group which has added another notable chapter to our archives.

ONE WAY OF DOING IT

Dr. O. E. Wilson, secretary of the Elkhart County Medical Society, presented to that group one of the most comprehensive reports of the recent Secretaries' Conference that has come to our attention. The usual report, if any is officially made, is something like this: "I recently attended the Secretaries' Conference, down in Indianapolis; the attendance was rather good and some of the speakers really had something to say. The turkey dinner was unusually good."

Not so with Secretary Wilson; it is evident that he had looked over the program before leaving home and found therein some subjects in which the members of his local society should be interested, hence, he decided he would attend the meeting and listen with an attentive ear to what was going on—and it is evident that he did just that.

His report covers some five pages and begins with a personal comment on the Wagner-Murray-Dingell Bill; this comment, by the way, indicates that Secretary Wilson knew what the bill was all about; he had read it; he had studied it.

He quoted from a recent statement made by former Congressman Pettengill concerning the promises made by the proposed measure, including almost everything that happens to the average American family. He states, "The definition of purposes in the Wagner-Murray-Dingell Bill is couched in the language of true humanitarianism."

The secretary also quotes liberally from the talk made before the mid-winter session of the Council by Dr. J. T. Oliphant, president of the Indiana State Medical Association, whose remarks were a classic and already have gone into the history of Indiana Medicine as being one of the best addresses made before a medical body.

The following is a personal analysis of many features of the proposed measure—most admirably done; it is an intelligent, understandable presentation.

The secretary injects a good story into his report, one quite apropos to the situation: "Two water-shy Negro lads on a troop transport were gazing dolefully at the growing expanse of water which lay between them and the vanishing dock. When there was nothing but sea in sight, one soldier miserably groaned, 'I knew the ocean was big, but I never thought it'd be this big. Did you ever see so much water in your life?' 'That ain't all,' returned his buddy, 'you're just looking at the top of it!'" The application of the story is, of course, that too many of us have looked just at the top of the proposed legislation under discussion.

He then asks, "Now, what are *you* going to do about it?" The various organized medical groups are at work on the matter, but it is essential that the individual society member interest himself and get to work. He also emphasizes the fact that it will not do to get angry about the whole mess; rather, we should approach the discussion of the matter with our patients and friends in a quiet, logical manner. He also gives some wholesome advice to those who essay speaking to lay groups on the subject, the important thing being to know what you are going to talk about.

This report, as we have said, is outstanding; it indicates that the writer attended this meeting with the idea that he was going to get some information, and having gotten just that, he wants to tell his confreres all about it.

If some representative from every county society in Indiana would make a similar report, the physicians of this state would be the best-informed group in the country. Too often the representatives who attend such meetings declare the program to have been extra good, then go home and forget all about it.

We can lick any anti-medical legislation that may be proposed if we but set ourselves to the task. In order to ready ourselves for the job, however, it is vitally necessary that we have plenty of information on the subject, and it is such a report as Secretary Wilson gave his home group that makes the information available to all.

BRITISH HEALTH IN WARTIME

Great Britain is now in its fifth year of war, and a consideration of the health of her peoples is well worth while. The British Information Services sends us an informative, factual statement on this subject, which makes interesting reading. It states, "The year 1942 was remarkable for a series of favorable records in vital statistics."

The birth rate was 15.8 per 1,000, the highest since 1931, while the infant mortality rate was 49 per 1,000. The death rate for female civilians was 6.84, 8 per cent better than in any previous year, while the rate for civilian males, 9.52, was the lowest ever recorded.

Since 1940 the Ministry of Health has been studying the heights and weights of school children in several different areas and found that for the three-year period there has been no variation in this regard.

An important survey was made of some 1,500 families in rather overcrowded districts, in which it had been feared medical services might not have been up to normal, this chiefly due to so many physicians having been called into the armed services. Here it was found that the health of these people was better than in former years.

"There has been a distinct check in the war-time increase in the death rate from tuberculosis," says the statement, the number of deaths from this cause in 1942 being the lowest on record. Much of this is credited to the newer method of chest examination, using what they term the "miniature x-ray photography." Further, a plan has been developed whereby those who leave remunerative employment to undertake treatment for pulmonary tuberculosis are given a special allowance by the government.

The number of civilian and service patients reporting for treatment of syphilis has increased some 29.6 per cent over 1941. It is stated that reliable figures as to gonorrhea are not to be had, but that it is believed that during 1942 the number of new infections have been six or seven times higher than in syphilis. It was early determined that the spread of venereal diseases came through a small group of "irresponsible" people who refused to take voluntary treatment, hence the Government took some rather drastic steps. It was made an offense for any person indicated as a source of infection to at least two patients under treatment to refuse medical examination or treatment by a special practitioner, after such a person had been officially ordered to do so.

It is stated that an American film which dramatizes the effects of syphilis was widely shown and had a most salutary effect on the populace. This film was shown in some three hundred theaters, one of the better results being a frank discussion of the venereal disease problems, while heretofore—due to such evasion as existed in this country for so many years—this subject was avoided in polite circles.

In conclusion, the report stated that new low records in the death rate from any disease were established, including pneumonia, influenza (the present epidemic of the latter is, of course, not included), scarlet fever, rheumatic fever and gastric ulcer.

One can but wonder just how much influence our "lend-lease" program had to do with this very imposing health report. True it is that this country furnished England with many articles of food that probably they otherwise would not have been able to obtain—many foods of the "must have" variety.

One important observation may be drawn, that even though a nation be embroiled in the worst war in the history of the world, the health of its people remains uppermost in the minds of the leaders of that nation. Health must be maintained at all costs; it is as important as conducting the actual warfare itself.

Editorial Notes

Edward H. Cary, former president of the American Medical Association, makes this statement: "This country has been drifting away from competitive enterprise, without which the present high standard of American Medicine could never have been reached. Socialization of medicine or any other profession would start us backward to the Dark Ages."

Last month THE JOURNAL carried a suggestion from an overseas member to the effect that where several Indiana physicians were in the same area, it might be well to have a regular correspondent for THE JOURNAL. This idea is good; it would mean that we can increase the interest in our military notes, a department that has found high favor among those in service. At the same time it might be remembered that notes from individuals, telling where they are and what they are doing, will find a most hearty welcome at our office.

The Indiana University School of Medicine scored another "direct hit" when they successfully combatted an outbreak of "polio," occurring in a group of soldiers from the West Coast. It is stated that thirty-four suspected cases were sent to the medical center, twenty-two of them actually having the disease. Out of this group one died, eighteen were cured and but three suffered crippling defects. The latter group was sent to Billings Hospital where measures are being taken to restore them to normal health.

Again we note the news story that London physicians have found a "sure cure" for cancer of the prostate gland, even though this has not definitely been proved. It is to be regretted that such premature announcements continue to be made. We recall that a few years ago a California group made a similar announcement, with the result that numerous victims of this disease made a trip out there, many of them finding it all to no purpose. We trust the time soon will come when all matters of publicity, as it relates to medicine, will come from duly-accredited and authentic sources.

Our Bureau of Publicity continues to do a good job, carrying on the work started by the late Dr. William Niles Wishard, Sr. We note a paragraph in a recent release that indicates just how valuable the weekly letters to the Indiana press may be. It refers to the tuberculin tests now so commonly made on school children. It is but natural that parents who are advised that such a test showed a positive reaction would be duly concerned about it. The statement of the Bureau, however, would tend to set the mind of these folk at rest, at least to some extent. The statement says, "A positive reaction does not necessarily mean that a child has tuberculosis," then goes on to explain the matter in detail. Such work is of inestimable benefit not only to the profession itself but to the reading public of the Hoosier state.

Well, here it is March again, and with the coming of that month the average person begins to ponder the question of a vacation. It will not be the planned vacation of some years back when we would comb the country for some new spot to visit, make a trip to the sporting goods stores to see what was new in fishing tackle, look over the clothing equipment once thought so necessary to a fishing expedition, or visit the railway ticket offices or the headquarters of our motor club in search of road information—that is out for the duration. Now our chief problem is, "what to do about taking a little vacation, just to get away from the grind for a few days." Every doctor should take a few days off, if it means nothing more than going to some nearby spot where he can rest and take it easy. You need this little respite, and you will render much better service after you have returned to your practice. Get busy on some plan for the coming summer.

We have been voting since 1896, and in the years that have followed have taken a more or less lively interest in political matters. And in all those years we have never known of a situation such as now exists in many sections of the country. With the May primaries coming along, we usually have a host of candidates for all sorts of offices, these announcements usually being made months in advance of the primary date. This year, however, it seems that most every candidate is jockeying for position; they are slow in making public announcement of their desire to be of service to the community. This is, of course, due to war conditions plus the fact that in elections recently held in various sections of the nation there have been plenty of upsets. It is our opinion that the voting public is doing a lot of self-thinking; that they will no longer permit professional politicians to make up their minds for them, and that they plan to approach the election, come next November, with a decision made only after a careful study of matters economic.

Maurice Early, of *The Indianapolis Star*, says that it took the farmers one hundred years to learn that soybeans might be regarded as a valuable crop, but that the present war has shown the value of this crop to such a degree that Indiana, together with four neighboring states, produce nearly the entire American crop. With much of the vegetable oil supply cut off by the war, something had to be done as a replacement, and it seems the lowly soybean filled the bill. One Indianapolis restaurant advertises that all its salads, using an oil base, are made from the edible soybean oil.

It is apparent that the millions of home gardens operated during the growing season of 1943 will be markedly increased, this year and that, with proper growing weather, the crop of vegetables thus raised will exceed that of last year. Notwithstanding the fact that doctors are busy folk, we advise everyone to have at least a small garden plot, if nothing more than a few tomato vines. We know of nothing that pays so well, in the crop harvested as well as in the exercise attendant upon a bit of gardening. Better look over that seed catalogue right now; the supply of many seeds is none to great this year and the one who orders early gets the cream of the crop.

We join with all other state medical magazines in welcoming into our group *Arizona Medicine*, the first number of which has just reached us. For many years past Arizona has been united with outer states of that area in the publication of *Southwestern Medicine*, which recently discontinued publication for the duration. Dr. Frank J. Miller, of Phoenix, is the editor of the new publication, with Drs. J. D. Hamer and D. F. Harbridge of the same city as associate editors. *Arizona Medicine* comes out in a bright, new dress, the printed pages being easily read and, judging from the salutatory editorial comment, we may expect much of value in the future.

It seems that the editor of the *Rocky Mountain Medical Journal* recently had some trouble with the eyepiece of his microscope. It had become soiled and all efforts to clean the same were in vain, notwithstanding the fact that he had tried practically all the solvents found in a modern medical laboratory. Before sending the part to the manufacturer, however, he thought he would try just one thing more—common soap and water. Much to his surprise, this did the trick and the said eyepiece again became usable. He was so delighted with the discovery that he promptly wrote an editorial, "Soap Still Cleans."

That reminded us that one of Chicago's hospitals uses nothing but good soap, plenty of hot water and a lot of elbow grease to keep the institution in a proper state of cleanliness.

The chemical laboratory maintained by the American Medical Association warns that there is a let-down on the part of some drug manufacturers, their products not being up to standard. It therefore behooves us to use the products of those firms with a reputation for reliability.

Reports concerning the successful use of penicillin continue to filter in, and it is to be hoped that soon there will be a sufficient supply for civilian use. *The Journal of the American Medical Association* recently reports a case of gas gangrene in a child which had resisted all forms of treatment, yet responded to the new drug.

NOTICE!

THE JOURNAL office has been moved to Room 1017, Hume-Mansur Building, which is on the same floor as heretofore. You will pass the office as you go by to the headquarters' office, so it will not be out of your way to drop in. We are not yet in a position to give the new telephone number, but it will be listed under the Indiana State Medical Association.

The Goshen News-Democrat, in an editorial on "Socialized Medicine," wisely points out a fact that many folk have overlooked:

"Advocates of the socialized medicine program included in the new Social Security Bill pending in Congress answer objections to the bill by saying that there is nothing in the measure which prevents free selection of physicians by the patient, and that any person can choose the doctor he wishes. That is indeed true, *but it also is true that the patient is compelled to pay for the physician he does not want, as well as the one he chooses.*

"In other words, the patient has free choice as long as his choice coincides with the Government's, which is virtually no choice at all."

The Rush County Medical Society thus warns the public of that county as to the dangers of smallpox and diphtheria:

"Smallpox vaccination and diphtheria immunization give individual protection against these diseases. At present, Rush County is open to the ravages of these contagious diseases because parents have not obtained for themselves and their children these simple and effective measures of disease control. Your medical doctor can advise you in this important matter.

"Published in the interests of the public health by the Rush County Medical Society."

Such publicity is the very best form of combating these diseases, and the Rush County group is to be congratulated upon this step.

We have been looking over some clippings taken from the Indiana press, probably forty or more newspapers. Every one of these newspapers is very much opposed to the regimentation of the medical profession, some of them printing lengthy editorials on the subject. Added to this is the opposition that has developed in many business organizations, notably the Indiana State Chamber of Commerce. As we so often have said, legislation along the lines of the Wagner-Murray-Dingell law would get nowhere were the reading public properly advised as to just what such measures really mean. When an attack is made on the medical profession it is hitting the average home, for we do have a lot of folk who still have a high regard for their family doctor. They do not want him fettered, nor do they want some political appointee to say when, under what conditions and from whom they can have medical attention. Our greatest weapon for combating such matters is by acquainting our folk with what such measures really mean to them.

It now appears that the City of Indianapolis is to be awakened to the fact that traffic regulations, insofar as they relate to pedestrian traffic, have not met with the enforcement usually noted in other cities. A news story is to the effect that the International Chiefs of Police Organization is to release a report on traffic conditions in that city.

Already in 1944 there have been seven pedestrian deaths, together with a large toll of injuries. To one who frequently goes to the capital city and has occasion to use the streets thereof, the reason is obvious—it is apparent that the average driver in that city, together with the average streetcar motorman, holds that the lowly pedestrian is but a nuisance and has little right to cross a street intersection.

In most cities the pedestrian, once he starts across an intersection with the proper light, is permitted to complete that crossing. Not so in Indianapolis, however—once the driver gets the go sign, he just goes and it is up to the pedestrian to be on the alert.

Our personal experiences have been such that we never start across an Indianapolis street intersection until we have the proper light all to ourselves, thus being fairly certain that we can make the other side before the light changes.

It might be well to advise the drivers of that city of the fact that the law provides that "A pedestrian crossing or starting to cross any such crosswalk on a green or go signal shall have the right-of-way over all vehicles and streetcars, including those making turns."

This law, so we are advised, has been upheld by the United States Supreme Court. We are personally pleased to note that it now seems that steps will be taken to enforce the laws.



President's Page



Recently a congressman was shocked when a Washington physician demanded a fee of one thousand dollars for confining the congressman's wife. This congressman told his legislative colleagues about it and thus gave the proponents of socialized medicine an opportunity to denounce all Washington doctors as racketeers.

A young woman from Indiana went with her husband to New York, where he was employed at a moderate salary. In due time she had occasion to consult an obstetrician. Her friends recommended a fashionable and a popular physician, and she went to see him. This doctor advised her that the old-fashioned way of getting babies into the world by muscular propulsion was out of vogue in New York City. The modern way, the procedure of choice, was to deliver all patients by cesarian section. This operation he was prepared to do for the modest fee of one thousand dollars.

The thing about these cases that makes the crime more heinous is not the fact that these doctors robbed their patients, but that they won the patients' confidence and led them to believe that such fees and such criminal practices were the best medical service.

Fortunately, Indiana is too provincial to be good hunting ground for such gaudy wolves. There are a few men practicing medicine in this state who through avarice and dishonesty betray the confidence of their patients, but there are no more thieves among physicians than can be found in a like number of individuals from any other business or professional group. Even the cloth of the clergy sometimes covers the heart of a rascal. All bankers are not to be condemned because a few bankers abscond, neither should all physicians be censured because a few of their number are dishonest.

Obviously, at a time like this when the eyes of the nation are turned upon its doctors, when the people are trying to evaluate the services of the medical profession, avarice and petty dishonesty on the part of a few can be very embarrassing.

This situation is a difficult one to deal with, but there are ways for each medical society to let unethical members know that crooked practices are not popular.

Josephant

THE RHODE ISLAND CASH SICKNESS COMPENSATION ACT*

JOHN E. FARRELL†

PROVIDENCE, R. I.

That you may better understand the Rhode Island Cash Sickness program, and that you may at the same time determine to some extent whether such a plan would be adaptable for Indiana, or any other state, it must be presented to you with a brief background of past actions leading to its adoption and with comment on the unusual local conditions which have made it possible to put it into operation.

When the Technical Committee on Medical Care to the National Health Conference made its report in 1938 it included as its fifth recommendation that federal action be taken toward the development of programs of disability compensation, and in its conclusions on this recommendation it pointed out that in good times and in bad times sickness is a major cause of poverty, destitution, and a large part of all dependency.

Subsequently, in September of the same year, at a special meeting in Chicago, the House of Delegates of the American Medical Association reviewed the entire report of the Technical Committee, and it adopted a motion of the Reference Committee relative to Recommendation V on insurance against loss of wages during sickness, as follows:

"In essence, the recommendation deals with compensation of loss of wages during sickness. Your committee unreservedly endorses this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and recovery, which function should be performed by a qualified medical employee of the disbursing agency."

I shall show you shortly how the latter part of that motion is impossible under the Rhode Island Plan, but for the moment I wish to direct attention to the fact that here was the mutual approval by both organized medicine and an agency appointed by the President to explore the expansion of benefits under the then recently-enacted Social Security Act, on a proposal which while not primarily part of a medical care program is nevertheless closely interrelated to it.

Rhode Island was the first state to approach that problem on a state level and to establish a cash sickness compensation program with limited federal assistance, of which I shall speak later. Again, it is necessary to view the local conditions that you may understand how Rhode Island has been in

a position to experiment at its own expense where other states could not.

The most densely populated state in the country—with 674 persons per square mile—Rhode Island is better than 91 per cent urban. It was sixth high in per capita income payments in 1940, and it exceeds all other states in per capita industrial output. It is one of the four states requiring employees to contribute to Unemployment Compensation funds, and of the four (Alabama, California, New Jersey, and Rhode Island) its levy, until last year, was the highest of any, being 1½ per cent on the employee on his earnings up to \$3,000. The employer, of course, also contributes 1½ per cent.

As the result of this taxation the Unemployment Compensation Fund had built up a reserve in 1942 which approximated twenty-eight millions of dollars, and there was agitation in some quarters for a repeal of the employee tax, such as Kentucky enacted that year. However, there were forces at work who did not wish the employee tax eliminated, and as a result an alternative program was devised in the form of cash sickness compensation benefits. Briefly, the proposal was this: that 1 per cent of the 1½ per cent of the tax on employee's wages be diverted into a separate fund to be administered by the Unemployment Compensation Board and to be known as the Cash Sickness Fund, the remaining ½ per cent to be continued into the Unemployment Compensation reserve.

It is significant to note that the legislation received no opposition. From the public viewpoint it was acceptable because it imposed no new taxes, and it offered additional social security. Labor supported it for personal reasons. The state favored it because it provided an expansion of state service to the citizens, and it offset possible federal legislation which would have jurisdiction over local conditions. The medical profession, as I have indicated above, was committed to this type of program, and since medical services were not involved the only concern of the doctors was the broadness of the definition "sickness," and the fact that the method of certification of illness was a matter left to the discretion of the administering board.

Thus the act was passed without dissent by the legislature, to be effective May 10, 1942. Transfer of the one per cent on employee wages to the Sickness Fund was effective the first of June, in 1942, but no benefits were paid until April 1, 1943. The purpose of this action was to allow the accumulation of a reserve fund that the program might be firmly established financially once it was in operation.

Now, briefly regarding the operation of the Sickness Act. It is administered by the same three-mem-

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, January 23, 1944.

† Executive Secretary of the Rhode Island State Medical Society.

ber board (one representing industry, one labor, and one the general public) which is appointed by the governor to administer the Unemployment Compensation Act which is effective for all employers of four or more individuals. The sickness measure is binding only on those who are subject to the Unemployment Compensation Law. Payments to the funds are made by the employer quarterly, with the 1 per cent of the employee tax specifically made payable to the Cash Sickness Compensation Fund, which is independent of the Unemployment Compensation Fund in every respect.

To be eligible for benefits a claimant must have earned at least \$100 in covered employment during the previous calendar year. Tables showing benefit credits and weekly benefit rates ranging from \$6.75 to a maximum of \$18, identical with the unemployment compensation benefits, are written into the law. Thus, if a worker earned \$1,000 during the base period, the previous calendar year, he would have a total benefit credit of \$205. If his highest quarterly wage during that base period was \$250 he would be entitled to a benefit rate of \$13 weekly, which would give him slightly more than fifteen weeks of compensation. If his highest quarterly wages approximated more than the \$250 he would receive a higher benefit rate for less weeks, but in either case he would still be eligible for his total benefit credit. Incidentally, the worker is eligible for unemployment compensation or sickness compensation, according to the condition which results in his being out of work, but he doesn't draw from both funds at the same time. And what he does with the money he receives is his concern alone. There is a one-week waiting period required prior to the payment of any sickness compensation benefits, and in order to qualify for credit during this waiting period and for each week in which he claims benefits thereafter, a worker must, by board ruling, obtain a statement from his attending physician that he is unable to perform any services for wages. The board is empowered to require by regulation that any claimant submit to a reasonable physical examination by experts appointed by the board. Appeals upon the denial or non-payment of claims may be made to the board and to the courts.

Right here let me point out the position in which the medical profession has been placed. I do not know what the House of Delegates of the American Medical Association had in mind when it adopted the motion previously referred to relative to the certification of sickness by qualified medical employees of the disbursing agency. In our case we have approximately 380,000 persons covered by this sickness program, and with payments going out weekly to about 5,000 persons, how any one staff of medical employees could certify all the sickness claims is beyond my comprehension.

Our problem has been a vexing one. Upon the medical profession rests in large measure the success of the program, since the individual doctor certifies to the board concerning the illness of his

patient who is a claimant for sickness compensation. To date we have tried to cooperate in every way with the board, but we have so far been denied a medical advisory committee. There is a paid three-member medical staff of the board which views claims and also examines claimants to determine extension of benefits. We are hopeful that the conflict in this phase of the program between the medical profession and the board may soon be eliminated.

The major issue for the doctors is the broad definition of "sickness" which is given in the Act as follows:

"An individual shall be deemed to be sick in any week in which, because of his physical or mental condition, he is unable to perform any services for wages."

From this definition it is apparent that the private physician must not only certify to his patient's illness, but he must also assume the responsibility of certifying as to the ability or inability of the patient to do *any* work whatever for wages. The resulting situation for the doctor poses a conflict between conscientious duty to the law of the state, on the one hand, and on the other hand consideration of the successful continuance of his professional work, which depends in no small measure on public good will, with the cash benefits the taxed patient seeks as the weight in the balance.

The dilemma may be solved somewhat this year if the proposal of the board is accepted by the legislature that the definition of sickness be further amended to provide that a person must be "*wholly* incapable of performing services of any kind or nature for wages."

In its original form the Act denied benefits to any individual who was receiving payments at the same time under the Workmen's Compensation Act, and to any individual who was receiving remuneration in the form of wages from an employer. However, within two weeks after payments of benefits was started in April, 1943, the General Assembly amended the law to provide that sickness benefits should not be denied persons in these categories. This action has been subject to criticism as it changed the original concept of the program, and it offered an opportunity for some individuals to receive more money while ill than would be earned during a similar period of employment. Thus, a worker who had earned \$35 weekly could receive \$20 weekly from the Workmen's Compensation Fund, and \$18 weekly from the Cash Sickness Fund. Under such circumstances it is easy to understand the danger of malingering, and the corresponding pressure on the physician in certifying the claim for benefits for his patient.

Within the past two weeks the Unemployment Compensation Board has had introduced in the Assembly amendments to provide the return to the original form of the Act, but the success of the effort is a matter of conjecture. It is significant to note, however, that during July, 1943, there were

1886 workers who filed claims for cash sickness benefits because they had suffered an industrial accident or occupational disease, and the fund had to pay out to them \$228,155 which represented more than half the total disbursement for that month. Undoubtedly most of these workers were entitled to workmen's compensation benefits because of the nature of their disability.

Before discussing one last phase of our legislation setting up this program, I should like to give you a brief idea of the financial structure of the fund as it now stands. From the first of April, 1943, until September 30, the income from contributions, less one per cent allowed for administrative expense, amounted to approximately \$2,432,000. During the same period approximately \$1,884,000 was expended in benefits, leaving an accumulated surplus of better than a half million dollars.

The fact that the payments in December amounted to only \$294,000, the lowest monthly figure since last May, would appear to indicate that no excessive drain will be made on the fund during the winter months when illness is more prevalent. As a result the fund is expected to finish its first year of operation next April with an operating surplus of close to \$850,000. This money, added to the contributions received from June 1, 1942 to April 1943, when no benefits expenditures were made, will give a reserve fund of more than \$3,500,000 with which to meet future demands.

But to protect the program from postwar demands which may deplete it, legislation has now been placed before the Assembly to provide for the addition of the remaining $\frac{1}{2}$ per cent employee contribution to the sickness fund, and also for repeal of the provisions for payments to workmen's compensation beneficiaries and workers who continue to receive their regular wages when ill. However, any of you who have had experience in legislative work will recognize the tremendous task ahead to alter a program which is at present financially sound and paying generous dividends so that it will pay less to beneficiaries in order to build a larger surplus. In all probability labor will defeat these amendments, if for no other reason than the fact that they would deprive it of any direct voice in the Unemployment Compensation Fund, which would automatically exist only by reason of employer contributions.

Perhaps you are wondering about federal participation in the program. It exists directly by reason of the fact that Unemployment Compensation is a federal-state organization, and the utilization of its personnel and facilities for the administration of the Cash Sickness Act must have federal permission. It is apparent that the facilities already existing within the Unemployment Compensation Service could be duplicated to carry out the provision of the disability compensation program only at great expense and inconvenience to all parties concerned. Therefore the combination of the services for the present is not without merit.

However, there is a more serious threat with which we are concerned. As you must have surmised, the legislation creating our program of sickness compensation had the benefit of review by members of the Federal Social Security Board, and suggestions and comments were solicited and received from them. Most disturbing to us was the inclusion in the Rhode Island Act of a section which provides that "should the social security act be amended to permit funds granted under Title III thereof to be used to pay expenses of administering a sickness compensation law, such as this act, then from and after the effective date of such amendment the expenses of administering this act shall be paid out of said unemployment administration or any other account or fund in which funds granted under said Title III shall be deposited."

In this provision, and in the provision which restricts the state agency to the maximum of one per cent of the contributions of each year to be used in the payment of the expenses of administering the program, we fear a loophole has been left in the law in which the wedge of federal intervention might eventually be inserted. A year ago last December committees of the Rhode Island Medical Society reviewed the legislation on this point with the board, and urged an amendment to provide sufficient funds for operation of the sickness act independently of federal assistance. Two weeks ago such an amendment, requesting 3 per cent of the contributions for administrative purposes, was presented by the board to the General Assembly. We hope it will be enacted as law, and that thereby we will make the first step in freeing our program of federal obligations.

While Rhode Island may be in a position to become financially independent in the administration of its program, many of us realize that other states may not wish to assume that responsibility. Therefore, we look with some concern on the section in our Act, which the Federal Social Security approved, intimating an amendment to Title III would be an easy way for any state to secure administrative funds to set up a cash sickness program.

Perhaps you are wondering if Indiana could establish a disability compensation program comparable to that in Rhode Island. You could, although I foresee difficulties for you in making the start at this time when proposals for further payroll deductions are not welcomed by the worker. You have an experience rating law here which results in a variable return on unemployment compensation funds, with the employer as the sole contributor. To duplicate the Rhode Island program you would either have to ask for a new tax on the employee to pay for the disability compensation, or you would have to turn to industry for cooperation in working out a new scale of employer-employee benefits on a fixed basis to assure a consistent income to finance both unemployment and sickness compensation.

I have spoken at length relative to the Rhode Island Cash Sickness Compensation Act as I in-

ferred that that measure was the one in which you are particularly interested. I would like to transgress on the time allotted me to speak briefly of another outstanding issue now facing us.

Last January fourth the Governor of Rhode Island announced to the General Assembly at the opening of the current session that he had conferred with leaders in the field of medicine, hospitalization, persons interested in hospital insurance and many other civic-minded citizens with respect to the question of adequate hospitalization at minimum costs for as many citizens of the state as possible.

On the basis of this preliminary inquiry, the Governor advocates the passage this year of a compulsory hospitalization insurance law which might operate somewhat along the following plan:

Every employer would be required to certify to a designated state agency that each of his employees owned a contract to provide hospitalization. The contract could be had through Blue Cross or any other authorized insurance company willing to insure for minimum benefits for a stated number of days.

The individual contract could be provided on an equal employer-employee basis, with quarterly payments made directly to the insuring agency by the employer.

The date of actual operation of such a plan would depend upon the time when increased facilities would be available. In other words, the passage of the compulsory hospitalization insurance law now would be done to provide the hospitals with assurance of a steady income for maintenance costs for additional facilities which they now hesitate to

create for economic reasons. The principles upon which the Governor predicated the hospitalization insurance law will interest you. They are as follows:

(1) Utilization of existing facilities wherever possible, always avoiding the expense incident to the creation of new and duplicating facilities.

(2) Compliance with the principles and practices of the professions or institutions to be affected by a proffered program.

(3) Coverage in any program devised for as many people as possibly can be included.

(4) Encouragement of the participants in a program which usually means industry and the worker to assume and share together financial responsibility for a program with a minimum state participation.

(5) Avoidance of federal or state domination and control of programs and the utilization of the organization and facilities of the institutions most affected by the program.

While there are many side issues involved in the enactment of a program such as this, I think that you will agree with us that we are engaged in some forward thinking on social security. The Rhode Island Medical Society, I am proud to state, has taken leadership in the matter, and this week our council approved of a proposal by the President of the Providence Medical Association, made prior to the Governor's address, that a state-wide voluntary council on health, consisting of representatives of industry, labor, state government, the public, and the professions be established to study and report on health security plans for the citizens of our state.

HOSPITAL PLANS IN INDIANA*

CHARLES N. COMBS, M.D.

TERRE HAUTE

When asked to speak on this topic two months ago, it was expected that the Indiana Plan would be almost ready for operation, but difficulties and delays have left it in a nebulous state. Nevertheless, very definite progress is being made and without doubt the final details will be worked out shortly.

In 1929 Group Hospitalization began in Baylor Hospital, Dallas, Texas, where its charter subscribers were school teachers. This novel idea spread rapidly through Texas, migrating to New Jersey and then far and wide. Without previous actuarial experience many of these plans were wrecked on financial reefs. Over-energetic promoters with high-pressure campaigns resulted in more grief than protection, and it is still not popular in Dallas, to

this day. Even old-line insurance companies avoided it as having too many unpredictable risks. However, as recently as eight years ago accident and health insurance companies found it really a paying field and began to sell on a group pay-roll basis. Of recent years the contracts have been more or less standardized under a national organization termed the Blue Cross, and by this name it is now generally known.

The existing insurance laws in most states permitted such an arrangement, and in practically all the remaining states the proper legalizing instruments were soon drafted. Legislative opposition in Indiana and Florida has held out to the last. For the past six or seven years Indiana hospitals have sought means to bring this state into line, and about that long ago the House of Delegates of the Indiana State Medical Association passed a resolution giving endorsement in principle.

An article by J. C. Furnas in the *Saturday Eve-*

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, January 23, 1944.

ning Post of October 2, 1943, acquainted millions of readers with the history of the development of Blue Cross. Indiana readers were given the inside story of why we are the only thickly-populated state in the Union that lacks Blue Cross insurance. I quote from the article: "For six years the Indiana Hospital Association and the Indiana State Medical Association have tried to get an enabling act out of the legislature preliminary to starting Blue Cross schemes. The first bill was pocket-vetoed because the title was faulty. The next time the bill was never let out of committee. The last time a bill to exempt non-profit hospitalization insurance from the jurisdiction of state insurance laws was reported out favorably by a judiciary committee, it was smothered when sent back to an insurance committee."

This week's *Time* again calls attention to Indiana's unique position. I quote, "Seventy-seven Blue Cross Associations cover the United States, except Indiana which has no law allowing non-profit group hospitalization, and serve 13,000,000 people. Though its financial problems seem to be licked and its popularity assured, the Blue Cross now faces a new potential threat, the Wagner Bill. In providing hospitalization for one hundred million United States citizens, the Blue Cross would be knocked into the emergency ward."

After our first bill to authorize the organization of a non-profit hospital service corporation had passed the legislature in 1939, but was vetoed by Governor Townsend, an effort was made in the 1943 legislature to obtain the passage of a similar bill. Mr. Albert Stump has given information to the effect that the insurance department of the state took the position that it would be a better and a sounder business venture if the hospital organized, under the present insurance laws, a mutual insurance company through which a non-profit plan could be worked out. They would then have the additional safeguard of supervision and other assistance that could be given by the State Insurance Department. The insurance commissioner, Mr. Frank Viehmann, has indicated his willingness to cooperate in working out a plan that would satisfy the requirements for Blue Cross certification and also the requirements of the laws of Indiana governing mutual insurance companies, so that non-profit service could be provided.

This year Mr. Frank G. Sheffler, president of the Indiana Hospital Association, appointed a committee consisting of Mr. Charles Jones, of Indianapolis, general manager of Block's Department Store and a board member of the Methodist Hospital; Lemuel Pittenger, of Selma, Indiana, President Emeritus, Ball State Teachers College and board member of the Ball Hospital; Benjamin Blumberg, Terre Haute, board member of the Union Hospital; Dr. John G. Benson, superintendent of the Methodist Hospital, Indianapolis; Sister Mary Reginald, superintendent of the Mount Mercy Sanitarium, Dyer, Indiana; Dr. Cleon Nafe and Dr. Carl McCaskey of Indianapolis, and Dr. Charles N. Combs

of Terre Haute. This committee has met with attorneys Claycombe and Stump, who represent both the hospital and medical associations. Through this committee the Hospital Association wants to work with the Medical Association in carrying out what the Indiana State Medical Association had approved by its action of the House of Delegates some years ago, and to set up its plans for non-profit hospital services in such a way that the medical profession will be adequately represented in the control of the instrumentality through which the services will be rendered. The committee has suggested control through a board of fourteen directors, as follows: (a) Three directors to be physicians nominated for this purpose by the Indiana State Medical Association; (b) three to be members of boards of control of hospitals to be nominated by the hospitals—some of these will be business men and executives of corporations so that the employers viewpoint will be represented; (c) three hospital administrators, to be nominated by the Indiana Hospital Association; (d) one nurse, to be nominated by the State Nurses Association; (e) one member of the A.F. of L.; one member of the C.I.O.; one member of the Indiana State Teachers Association, and one member of the Women's Federation of Clubs, each to be nominated by their respective organization. This tentative list may be subject to revision, but we have in mind that the Blue Cross plan requires that there be adequate representation on the board of both hospital representatives and doctors, and that there be a broad representation of other groups who might be interested in the success of the business. The further details of the hospital insurance company will be worked out between our attorneys, the insurance department, and the attorney general's office.

The element of this whole plan that is most important to the physician is the contract of the insured. The Hospital Association wants a definite and clear line drawn between what constitutes medical services and what constitutes hospital services, avoiding anything which could be criticized by the physician. For that reason the Hospital Association wants, for members of the board, physicians who will regard it as their duty to zealously safeguard the interests of the medical profession.

The contract covering the insured individual is being worked out along these lines: Standard hospital service will be rendered to a single subscriber at \$1.00 per month; and for a man, wife and unmarried children under the age of nineteen at \$1.75 per month. These rates may be modified, depending upon the ward rates which will be quoted by the hospitals before they sign the contract. Standard hospital service will include the following, only during such time as the member is under the treatment and care of a physician as a bed patient: (1) bed, board and general nursing service; (2) operating room service; (3) laboratory service except the following: (a) basal metabolism, (b) electrocardiograms, (c) microscopic tissue examinations, and (d) examinations requiring animal inoculations.

(most Blue Cross plans include x-ray service, but we shall attempt to exclude it if the inclusion would meet with the opposition of the medical profession); (4) drugs of the U.S.P., the *National Formulary* and the *New and Non-official Remedies*, and (5) usual surgical dressings. It is, of course, understood that industrial injuries or diseases will not be included because the employee is entitled to care under the Compensation Law. Obstetrical service will not be included until after ten consecutive months preceding the member's admission date.

Diagnostic or therapeutic services rendered by a physician, pathologist, roentgenologist or anesthesiologist to, or in the interest of, any individual hospital patient may not be considered as being in the category of a hospital service, and therefore fees for such treatment may be rendered separately and in addition to charges for hospital services as provided for under the terms of a hospital group-insurance contract.

In the event that a contractual arrangement now exists between a hospital and a physician, and there is no wish or desire on the part of either or both parties immediately to abrogate such contract, the hospital may act as the agent in rendering such service, or services, and fees for such services may be included under the terms of a group-insurance contract.

We hope that as soon as possible any existing contracts between physicians and hospitals will be revised so as to allow such physicians to regulate their own fees, but we have no criticism provided the local conditions are satisfactory to the county medical society and to the specialists involved.

A cash bond of \$25,000.00 will be posted with the State Insurance Commissioner, and beyond that reserve the hospitals will be liable for furnishing hospital care during the life of the contract even though the plan fails financially. In the event that no hospital bed is available in the community, a refund or equivalent compensation will be paid the members. The hospitals certainly can be absolved from selfish motives in promoting this plan, for at present they need no more business and, moreover, do not make money out of Blue Cross payments which are at ward rates, but they are willing to participate because it is in response to a public demand. The medical profession is often accused of opposing changes in the status quo but failing to present any new plan. The Blue Cross is such a plan to save the life and existence of voluntary hospitals, and all physicians are vitally interested. I recall my own early indifference, skepticism, and finally antagonism to group hospitalization, but such an attitude was due to former defects and the exploitation of physicians, which are now being corrected. The proposed contracts will be submitted to your local hospitals, and we want you to talk to the officials of your hospital—study the contract and see that in its final form it accords with your views. Until now lack of interest among the doctors has caused the hospitals to hesitate in pushing Blue Cross plans. Now that we are lagging far behind all of the other

states we must go ahead. In most hospitals a surgeon, or in the larger ones two or three surgeons, hold the steering wheel of the hospital, and if these key men will advocate this plan it will go over and they can at the same time see to it that no anesthesiologist, pathologist, or radiologist will be exploited under the contract. The services of hospital technicians will be sold under the contract, but not the services of a physician.

At the last meeting of the House of Delegates of the American Medical Association, in June, 1943, an unusual amount of time was given to the consideration of Blue Cross plans and the way certain of their contracts sell medical services. In many localities hospitals as corporations are engaged in the practice of medicine insofar as they include the services of an anesthesiologist, a pathologist, and a radiologist in a contract with a prepayment hospitalization subscriber. The American Medical Association at this time deems it unwise to make a generalized ruling but insists that local problems be solved by county medical societies. If this paper gains but one point, it would be to impress upon you Indiana doctors the necessity of reviewing again the situation in your home hospital, and if contracts or agreements between the aforementioned specialists are not to your liking, see that proper changes are instituted before the Blue Cross Plan is adopted in this state.

Having served for so long in the dual capacity of hospital administrator and at the same time a practitioner of medicine in a hospital, I have labored constantly to harmonize these two sometimes divergent views. I covet for this Blue Cross plan a further rapprochement between the business and professional viewpoints. While we should hold fast to all that past experience has proved to be good, we should secure out of the new the realization of better and better services to the public health.

Blue Cross plans have done much to enhance the popularity and prestige of hospitals. The idea of a practical system of budgeting, and regular payments to protect against the unforeseen medical disasters, makes an immediate appeal to common-sense management. If we hope to make compulsory hospital insurance unnecessary, the enrollment in Blue Cross plans must increase to 100,000,000 members rather than the 13,000,000 now listed.

Surgeon General Parran has just announced his desire to meet with a representative committee from the American Hospital Association in order that he may survey the situation. Two implications appear, and the final result may be that, first, the Blue Cross Plan will be considered adequate to supply hospital care to the public without the special provisions of the Wagner-Murray-Dingell Bill, or second, that governmental aid will be added to the Blue Cross Plan only insofar as it fails to reach the very low and unorganized wage earners. Mr. Altmeier, chairman of the Social Security Board, has proposed that the Blue Cross and the Government go hand in hand with the Federal Agency in caring for the neediest.

NATIONAL LEGISLATIVE PROBLEMS*

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The first session of the Seventy-Eighth Congress adjourned on December 21. At that time there had been introduced a total of 6,527 bills, 1,963 in the Senate and 4,564 in the House, including joint resolutions, concurrent resolutions and simple resolutions. About 4 per cent of these, or 280, were of sufficient medical interest to warrant abstracts of them being prepared for publication in THE JOURNAL.

In addition to this abstracting, more detailed summaries of the more important measures were included in the *Federal Legislative Bulletin*, prepared by the Bureau of Legal Medicine and Legislation and sent periodically to state medical associations and to others on the mailing list. Normally, this *Bulletin* is distributed monthly. It is supplemented by special bulletins, telegrams and letters whenever the need arises.

The monthly bulletins are factual in content. They present not only summaries of bills but excerpts from the reports of Congressional committees, from the testimony of witnesses before such committees, from discussions of senators and representatives on the floors of the Senate and House, and from public documents such as, for example, special messages sent by the President to the Congress, recommending legislation or transmitting estimates for additional appropriations to continue programs already in effect, or to initiate new programs.

FEDERAL FUNDS FOR RELOCATION OF PHYSICIANS

Such a special message was sent to the Congress, under date of October 9, 1943, asking for an appropriation of \$1,000,000 to be used by the United States Public Health Service to supply medical and dental care in critical areas. It was contemplated that the Public Health Service would use this appropriation to supply the needed care in one of two ways: (1) assign its own personnel to such areas to treat the civilian sick, or (2), induce private practitioners of medicine and dentistry to move into the areas by paying them \$250 a month for a period of three months plus moving expenses.

The House Committee on Appropriations to which this special message was referred refused to include the appropriation in the First Supplemental National Defense Appropriation Bill, H. R. 3598, stating that the committee hesitated to inaugurate a program of this character with federal funds to provide direct medical and dental attention to civilian populations with physicians paid by the Federal

Government. The Committee was of the opinion that out of the cooperative efforts of the Federal Government, the medical associations, the state departments of health, and the communities themselves there should come a concerted and spontaneous effort to supply the needs of the critical areas. Not until those efforts were made, or having been made, failed, should the Federal Government, the committee thought, step into the picture and do the job.

The Senate Committee on Appropriations likewise refused to amend the appropriation bill to include the requested appropriation. When the bill reached the floor of the Senate, Senator Russell of Georgia offered an amendment to provide a portion of the appropriation, \$345,000. This amendment provided for the use of the money by the Public Health Service in making the monthly payments to civilian physicians and dentists and in paying their moving expenses. The service was not to be authorized to send its own personnel into critical areas. The Senate accepted the Russell amendment. Later a conference committee agreed on a modification of it; that modification was approved by the Senate and House, and the bill was signed by the President on December 23 as Public Law 216.

As enacted, the bill provides \$200,000 instead of the requested \$1,000,000, does not authorize the Public Health Service to assign its own personnel to critical areas as initially contemplated, requires the requesting community to contribute 25 per cent of the costs, and specifically provides that the relocated physician or dentist must obtain a license to practice in the state to which he moves.

Preliminary steps have been taken to translate this congressional authority into action. Under date of January 12, the United States Public Health Service sent a letter to each state department of health, reporting the availability of this federal money to provide the services of physicians and dentists in critical areas. In this letter the service pointed out the main provisions of the law and the general conditions that must be met in order to obtain the benefits of it. It was noted particularly:

1. That a municipality, county, or other local subdivision of government may submit an application to the Surgeon General for the relocation of a private practicing physician or dentist in the applicant subdivision.

2. That such application must be duly approved by the state health department having jurisdiction over the municipality, county or other local subdivision of government.

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, January 23, 1944.

3. That the Surgeon General, on receiving such application, is authorized to enter into an agreement with a private practicing physician or dentist under which, in consideration of a relocation allowance of not to exceed \$250 a month for three months and the actual cost of travel and transportation of the physician or dentist and his family and household effects to the new location, such physician or dentist agrees to move to and engage in the practice of his profession in the applicant subdivision for a period of not less than one year.

4. That no such contract shall be made with any physician or dentist unless he be admitted to practice by the state authority having jurisdiction of the new location.

5. That each applicant subdivision must contribute 25 per cent to the total cost of such relocation allowance, travel, and transportation costs of each such physician or dentist and his family obtained by the applicant.

The letter calls attention to the fact that the State Procurement and Assignment Service in many states has already determined that certain areas are in need of additional physicians or dentists, and a list of such areas in the particular state is attached. State health departments are asked, in consultation with the state chairman of the Procurement and Assignment Service to re-examine the areas to determine their present status and to rate them in order of urgency.

It is pointed out that while the state health officer must approve the application, the State Procurement and Assignment Service Chairman has the responsibility for determining which physicians and dentists are available for relocation.

Similar letters have been sent, too, by the Central Board of the Procurement and Assignment Service to the chairmen of the State Procurement and Assignment Service, advising them of the availability of the federal funds for relocation purposes. Detailed information, together with application forms for use by subdivisions wishing to apply for the relocation of physicians and dentists, will be forwarded by the Public Health Service to state departments of health in the near future.

At the time this legislation was being given consideration by a subcommittee of the House Committee on Appropriations, Surgeon General Parran, United States Public Health Service, submitted for the record a tabulation of communities in need of physicians and dentists as of September 15, 1943, the need being made known by a joint survey report of the service and of the Procurement and Assignment Service, or by a report submitted by the State Chairman of Procurement and Assignment to the office in Washington or through determinations made by the Public Health Service itself.

This tabulation, which was said to be incomplete, indicated that there were at that time 213 communities in need of a total of 295 physicians and

53 dentists. The tabulation showed that in Indiana, for example, one general practitioner of medicine was needed in each of the following communities: Morristown and Shelbyville, in Shelby County; Bloomington, in Monroe County; Lawrenceburg, in Dearborn County; and Gosport, in Owen County. I assume that the letter that was recently sent to the state health department of Indiana was accompanied by a list of these communities.

During the course of the House and Senate hearings, apprehension was expressed on the part of committee members that this relocation program involved a socialization of medicine, at least a step toward such socialization. Questions were repeatedly submitted to witnesses in an effort to obtain views concerning the apprehension that the committee members obviously felt. Both Surgeon General Parran, before the House Committee on Appropriations, and Dr. W. F. Draper, Acting Surgeon General, before the Senate Committee on Appropriations, assured the respective committees that the proposal did not involve a socialization of medicine, nor did it constitute a step leading toward that regimentation. Surgeon General Parran furthermore gave assurances that the program was an emergency one, necessitated by wartime conditions, and that it would not develop into a permanent function of the service.

On the floor of the Senate a number of senators brought up for consideration the possibility that the authority contained in the appropriation bill might have the undesirable effect of injecting the Federal Government permanently into the field of the practice of medicine. It was only after repeated reassurances that these senators acquiesced in the adoption of the Russell amendment.

These facts may indicate a trend in the thinking of members of Congress on the general subject of the socialization of medicine, as contemplated in the bill about which you have heard so much this morning, the Wagner-Murray-Dingell Bill.

THE WAGNER-MURRAY-DINGELL BILL

The Senate version of that bill, S. 1161, is still pending in the Senate Committee on Finance, and the House version, H. R. 2861, in the House Committee on Ways and Means. So far hearings have been scheduled by neither committee. This legislation received the official blessing of the Secretary of the Treasury when he appeared before the House Committee on Ways and Means in connection with tax legislation. He advocated the enactment of what he referred to as the "pending legislation," proposing to increase the over-all social security tax to 12 per cent. He was obviously referring to the Wagner-Murray-Dingell Bill.

More recently, in his annual message to the Congress, submitted on January 11, the President, among other things, said:

"We have accepted, so to speak, a second Bill of Rights under which a new basis of security

and prosperity can be established for all—regardless of station, race, or creed.

"Among these are:

"The right to adequate medical care and the opportunity to achieve and enjoy good health;

"The right to adequate protection from the economic fears of old age, sickness, accident, and unemployment.

"I ask the Congress to explore the means for implementing this economic bill of rights—for it is definitely the responsibility of the Congress so to do. Many of these problems are already before committees of the Congress in the form of proposed legislation. I shall from time to time communicate with the Congress with respect to these and further proposals. In the event that no adequate program of progress is evolved, I am certain that the Nation will be conscious of the fact."

While the President did not in his message, and has not so far as I know, espoused the Wagner-Murray-Dingell Bill, he did and has in the past advocated the objectives of the bill so far as medical care is concerned.

Still later, the report of the Social Security Board, recently released, presented what in the opinion of the board was a comprehensive basic program of social security to include, among other things, insurance to cover the cost of hospital and medical care. The chairman of that Board, Mr. Arthur J. Altmeyer, has repeatedly expressed a similar viewpoint.

While Surgeon General Parran has been quoted as being against the enactment of the Wagner-Murray-Dingell Bill in its present form, another representative of the Public Health Service, Dr. J. W. Mountin, spoke openly in favor of the socialization of medicine when he addressed the Association of Interns and Medical Students in New York City, November 19, 1943, a copy of which address was printed in the Congressional Record for January 11 at the instance of Senator James E. Murray of Montana. Dr. Mountin said in part:

"The argument most frequently used by those who object to the remedies I have mentioned is that they will involve the socialization of medicine. The truth of the matter is that, although medicine is not today a social service, it has advanced a long way in that direction. And this trend has benefited not only the public but the medical profession as well."

And again:

"The foregoing account of tax-supported activities show clearly that government is both a large contributor and large operator in the field of medical care. In short, it shows that American Medicine is already socialized to a considerable degree, and that much of its excellence is due to the socialization."

Thus we have the two viewpoints as expressed by members of Congress hesitating to enact legislation

that will tend to socialize the practice of medicine and expressed by the President and by the Social Security Board advocating changes in the method of distribution of medical care that must inevitably lead to socialization and regimentation.

Just as a matter of record, here is what the recent report of the Social Security Board had to say about sickness insurance:

"Costs of medical care, as has been pointed out, are a peculiarly appropriate field for insurance provisions, since the problem does not lie in the average annual cost but in the uneven and unpredictable incidence of a risk to which nearly all the population is subject. These costs, as well as losses of earnings, constitute an important direct factor in causing dependency. Moreover, there is impressive evidence that the barrier of currently meeting costs of medical care keeps many individuals from receiving services which might prevent or cure sickness and disability and postpone death. From the standpoint of the general welfare and of safeguarding public funds for insurance, assistance, and public services provided in dependency, the Board believes that comprehensive measures can and should be undertaken to distribute medical costs and assure access to services of hospitals, physicians, laboratories, and the like to all who have need of them. For all groups ordinarily self-supporting, such a step would mean primarily a redistribution of existing costs through insurance devices. It should be effected in such a way as to preserve free choice of doctor or hospital and personal relationships between physicians and their patients, to maintain professional leadership, to ensure adequate remuneration—very probably, more nearly adequate than that in customary circumstances—to all practitioners and institutions furnishing medical and health services, and to guarantee the continued independence of non-governmental hospitals." [Pp. 37-38.]

Under the general heading of national legislative problems, there is one other matter to which I would like to refer in conclusion. At the last meeting of your House of Delegates a resolution was adopted, presented on behalf of the Lake County Medical Society, concerning the establishment of a Washington office by the American Medical Association. In support of the adoption of this resolution the following statement was made by a member of the Lake County Medical Society:

"The Public Relations man in our county is our secretary, and he tells us what we have to do is this: clean house first, and then you can go to the public and do something. The American Medical Association is getting some criticism, and some of it is needed; there is no question about that. Our county secretary received word the other day on this motion regarding funds for the aid of children—that it would not be called out of the Senate Committee before October fourth; that came from the gentleman from the

American Medical Association. The next morning he got another telegram that it had been reported out the day before, twenty-four hours after he had received word that it would not be reported out before October fourth. In other words, these men sitting in Chicago do not know what is going on down in Washington."

I am the "gentleman from the American Medical Association" referred to in the statement, I assume, since it is my job to keep in touch with legislation. The author of the statement infers that I misinformed the Lake County Medical Society concerning the status of the then pending legislation making appropriations for the obstetric and pediatric program for the wives and infants of servicemen. Where the author of the statement obtained his information, I do not know, because I had had no correspondence whatever with the Lake County Medical Society concerning the status of the legislation. The executive secretary of that society, in response to a letter from me about the matter, did not refer me to any such correspondence.

The Indiana State Medical Association received three communications from me about this appropriation measure, H. J. Res. 159. The President submitted his supplemental estimates to the Congress on Monday, September 20. On the following day I received in Chicago a copy of the special message and notified all state medical associations by means of a special bulletin of the pendency of the estimates. On Wednesday, September 22, the measure that had been formulated by the House Committee on Appropriations to make the requested money available, H. J. Res. 159, was passed by the

House of Representatives. On the following day, September 23, all state medical associations were notified of that fact. On Friday, September 24, the Senate Committee on Appropriations acted favorably on the joint resolution. On Saturday morning Mr. Hendricks telephoned me to confirm a report he had heard that on the previous day the Senate Committee had acted. I had not, at that time, received word to that effect and so informed him. I did confirm the report later in the morning and telegraphed Mr. Hendricks. The Indiana State Medical Association received no other communications from me with respect to the joint resolution.

At no time was it suggested to anyone that the Senate Committee would not act on the measure before October 4. To the contrary, in the special bulletin sent out September 21, Representative Cannon, the chairman of the House Committee on Appropriations, was quoted as saying that it would be necessary to complete Congressional action on the measure by October 1, due to the depletion of funds for the program.

I freely credit the author of this statement with good faith, for I do not believe he would deliberately support the resolution before your House of Delegates with false arguments. The facts, however, are as I have just stated. I refer to this matter as a national legislative problem because I think it does fall in that category.

(Dr. Doty and Mr. Hendricks responded to Mr. Holloway's remarks, and "everyone was happy ever after.")

SECOND INDIANA STATE MEDICAL ASSOCIATION INDUSTRIAL HEALTH CONFERENCE

During the year 1942 the Advisory Committee on Industrial Medicine of the Procurement and Assignment Service suggested to the Procurement and Assignment Service, and the American Medical Association, that a program be developed to train physicians for placement in war industries.

Dr. C. D. Selby, chairman of the Advisory Committee on Industrial Health of the Procurement and Assignment Service, and Dr. C. M. Peterson, secretary of the Council on Industrial Health of the American Medical Association, followed up this suggestion by requesting the Indiana State Medical Association, during its annual meeting at French Lick, to develop a program meeting the objectives advanced by Procurement and Assignment. Through the Committee on Industrial Health of the Indiana State Medical Association, with Dr. E. S. Jones serving as chairman, developed a program which was placed in operation in February, 1943.

The program had a two-fold purpose. The first objective was to offer postgraduate training for industrial physicians already in practice through

an intensive postgraduate course in order to lessen absenteeism due to illness. To fulfill the second objective a separate, more detailed course was developed to train physicians without previous industrial experience, for any vacancies that may be created in industry. This dual program became nationally known as the "Indiana Plan for Procurement of Physicians In War Industries."

Through this plan physicians have been secured for industry and, further, industrial physicians in practice were offered postgraduate training. It is the desire of the Committee on Industrial Health to continue, on an annual basis, the postgraduate courses. To that end, another conference is planned this year to be held in Indianapolis, April 19 and 20.

The program will cover the following subjects:

1. Records and record keeping in industry.
2. Industrial skin diseases.
3. Treatment of hand injuries.
4. Disability evaluation.
5. Lung changes in electric arc welders.

6. Value of industrial medical service.
7. Rehabilitation of physically handicapped.
8. Aluminum therapy for silicosis.
9. Employment of handicapped individuals.
10. Undergraduate and postgraduate plans.

The keynote of the program is the placement of the physically handicapped veteran in industry on

his return from the battle front. The Committee on Industrial Health is definitely of the opinion that physicians and industry should plan and train for this event before the boys come home, and not wait until the war is over.

Nationally-known speakers are being invited. Mark this meeting on April 19 and 20 as a *must* on your calendar.

"EMIC" PROGRAM AND FEE SCHEDULE*

ROBERT E. JEWETT, M.D.

INDIANAPOLIS

The "Emergency Maternity and Infant Care Program for the Wives and Infants of Men in the Armed Forces" has been given a capital letter title by the press, the profession, public-health workers, and the public in general. Although this practice gives rise to good-natured ribbing, an abbreviated title, such as "EMIC," is certainly handier for common use than the lengthy one occasioned by the Act of Congress of March 18, 1943.

The EMIC Program, to use the new title, has continued to expand in Indiana since its inauguration June 10, 1943. During the six-month period ending December 31, 1943, authorizations were issued for 5,988 obstetric cases and 706 pediatric cases, making a total of 6,694. During this period payment was completed for a total of 1,607 cases at a cost of \$141,544.85, an average of \$88.08 per case. Using these figures as a base, it can be estimated that the program will have cost more than \$1,200,000 for a full year, and this is approximately the estimate determined in the weeks preceding the inauguration of the program.

The difficulties attendant to establishing the administration of a program of this magnitude can scarcely be realized by anyone not involved in the process. For a public health agency, not primarily intended for such a function, to do so, makes the going doubly hard. The process has entailed the acquisition of a large clerical and accounting staff, at a time when such personnel are a scarcity, and the establishment of administrative procedures and policies almost without precedence in public health activities. Furthermore, a considerable strain has been put upon the Indiana State Board of Health to budget for the administrative costs since the Congress of the United States, in making an appropriation, failed to appropriate funds for administration. Nevertheless, improvement can be seen and we are approaching a time when cases may be processed with a minimum of delay.

Apart from the administrative problems, delays and difficulties arise and criticisms stem from mis-

understanding. Such misunderstanding still exists concerning the limitations of the program as established by the Federal Government, state regulations governing administrative procedures, and the need for care in revising policies and fees to meet apparent shortcomings in the program.

The Appropriation Act of Congress was not intended to establish a medical care program for any large population group. Rather, it was intended to insure the safe birth and well being of the infants of men serving in the armed forces. For that reason the Act limits care to the wives during the maternity cycle, and care of the newborn infant for one year. The Act stipulates that funds must be used to purchase medical, hospital, and nursing care with the legal implication that purchase of this care must be assured by authorizing and making payment directly to physicians, hospitals, nurses, and other persons or agencies providing this care. The Act further stipulates that any care authorized must be provided without additional cost to the patient or family, and this was intended to insure the wife or family from being charged over and above the amount authorized by a state health agency at a rate which would provide no savings at all. Such care is also limited to the families of men of the fourth, fifth, sixth, and seventh pay grades, the four lowest, limiting the service to those with a base pay of \$78.00 per month, or less. Finally, the Act stipulates that administrative plans of the various states must be submitted to the Secretary of Labor for final approval, thus rendering all policies, procedures, and fees subject to that approval.

State regulations, intended to insure the legal and safe expenditure of public funds, somewhat involve and delay processing of cases and the payment of fees and costs of service. However, we are making a continuous effort toward improvement and simplification, and we feel that necessary forms are in many respects simpler than similar forms required by private agencies and many insurance companies, although there is still considerable delay between the filing of reports and final approval of vouchers for payment. Delays are due in part to incorrect reporting by the physicians

* Prepared for the Advisory Committee to the Division of Maternal and Child-Health of the Indiana State Board of Health; H. F. Nolting, M.D., Chairman.

and failure to request authorization for their own or other special services promptly, since these mistakes require clarifying correspondence.

Although there is some impatience and criticism concerning the apparent inadequacy or lack of certain necessary fees for service, there is an understandable need for care in revising policies and fees. The Advisory Committee to the Division of Maternal and Child-Health of the Indiana State Board of Health has been aware from the beginning that certain inadequacies and ambiguities in fees would appear, and it has endeavored to provide for necessary revisions as rapidly as possible and as early as permission and approval of the Federal Government would permit.

The maximum limit to certain of the fees has given rise to misunderstanding and some criticism. These limits have been necessary since the total cost of the program, based upon the average cost per case, must be kept within the limits of the appropriation for the country as a whole. Therefore, increases in maximum fees can only be made when the appropriation is increased by an Act of the Congress of the United States.

The failure of the State Board of Health to authorize payment of fees for consultant services in certain instances has caused some rancor. However, this has been due to the failure of certain county medical societies to designate any of their members as qualified to perform major surgery, or to serve as consultants in any of the various specialties, as required by federal regulation. A request to select one or several consultants was sent to the secretary of each society some months ago, but all have not answered. Any society which has not done this should take steps to do so, and it should send a list of the consultants selected to H. F. Nolting, M.D., Chairman, Advisory Committee to the Division of Maternal and Child-Health, Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana.

The lack of additional fees for the attending physician for the care of complications and for

cesarean section has given rise to statements of dissatisfaction. However, since the request for authorization for care stipulates complete care at a cost not to exceed the maximum, additional fees for such personal service may not be allowed, although charges may be added for drugs or supplies provided by the attending physician at the cost to himself.

The absence of a method of payment to provide for travel in certain cases has met with justifiable disfavor. Strict regulations governing payment for travel of persons employed by the state has until this time prevented any feasible method of paying for travel of physicians participating in this program.

Most of the inadequacies pointed out have been apparent to all concerned, and we are happy to report that recent directives from the United States Children's Bureau will make it possible to revise certain policies and fees, at least during the next fiscal year. These revisions may make it possible to include payment for additional care of infants, to increase fees for pediatric surgery, and to provide fees for non-obstetric, intercurrent medical and surgical conditions. It should be emphasized, however, that revisions must be submitted to the United States Children's Bureau for approval, and that new fees established apply only to applications received on and after the official date of approval.

The Advisory Committee to the Division of Maternal and Child-Health of the State Board of Health will work as rapidly as possible to improve administrative methods and to provide needed changes in policies and fee schedules. Cooperation and understanding between the profession and the State Board of Health will certainly make it quicker and easier to resolve the problems attendant to this program.

The fee schedule which follows applies to all applications submitted after October 11, 1943, and it will be in effect until the above-mentioned revision is completed and approved by the federal agency.

FEE SCHEDULE FOR THE EMERGENCY MATERNITY AND INFANT CARE PROGRAM

This fee schedule applies to care authorized after October 11, 1943. It is tentative, pending anticipated revisions and extensions.

FEES FOR OBSTETRIC CARE

Complete Maternity and Newborn Care,
not to exceed -----\$50.00

This includes all care of the mother and infant during the prenatal, delivery, and postpartum periods, as rendered by the attending physician filing the *REQUEST FOR AUTHORIZATION*.

Complete Prenatal Care, with a minimum of
five visits -----\$10.00

When less than five visits are specifically reported, \$2.00 will be deducted for each visit less than five. *EXACT DATES OF PRENATAL VISITS MUST APPEAR ON REPORT.*

Labor and Delivery

For complete care during labor, delivery,
and immediate puerperium -----\$30.00

For abortion or miscarriage before the
seventh month of gestation -----\$15.00

For abortion involving dilatation and currettage	\$30.00
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Postpartum Care

For care of the mother for six weeks after delivery	\$ 5.00
For care of the newborn infant, including circumcision	\$ 5.00
For complete care of the mother and new- born and postpartum examination at the end of six weeks	\$10.00

FEES FOR PEDIATRIC CARE OF INFANTS UNDER ONE YEAR

Home—First visit	\$ 4.00
Subsequent visits	\$ 3.00
Office or Hospital—First visit	\$ 3.00
Subsequent visits	\$ 2.00

Payment will be made by visit according to the above rates, but it may not exceed \$13.00 for the first week and \$6.00 for subsequent weeks of authorized care. Authorized care is initially limited to a maximum of three weeks unless a request for extension of authorization, stating the indications, is made by letter, telegraph, or telephone. Each new authorization is limited to three weeks and payment may not exceed \$6.00 per week. The above applies to any single period of illness, and a request for a new authorization should be made promptly for subsequent illnesses by letter, telegraph, or telephone.

Immunization for Communicable Diseases

Complete immunizations for smallpox, diphtheria, and whooping cough will be paid for if the total amount does not exceed \$6.00. A charge of \$1.00 may be made for office visits involving inoculations. Immunizing material should be obtained from the State Board of Health, but may be included in the physician's bill if specified and a charge made at professional rates—15 per cent less than list price.

Pediatric Surgery

To include complete surgical care of the infant under one year of age.

1. Minor surgery, including pre-and post-operative care\$10.00
2. Major surgery, including entrance into the thoracic or abdominal cavities, and surgical treatment of congenital defects not otherwise provided for under services for Crippled Children. This also includes pre- and post-operative care\$30.00

SPECIAL AND ADDITIONAL SERVICES

A request for authorization must be made by the physician in advance or as soon as possible, giving the name of persons or firms providing services. (Form 317, MCH Series.)

1. Hospital Care

Hospital care will be authorized in hospitals approved by the Indiana State Board of Health, if a request is made before or at the time such care is begun. Authorization for hospital care is limited to two-week periods unless an extension is requested promptly by the physician, and the indications stated.

2. Obstetric Consultation

Services of a qualified consultant may be requested. A consultant must be a licentiate of his respective American Board, or must be selected from the approved list of consultants established upon recommendations of local medical societies and approved by the Indiana State Board of Health and the Advisory Committee to the Division of Maternal and Child Health. (Consultants include all specialties.)

1. Simple bedside consultation\$ 5.00
2. Consultant services, including assistance at the time of an operative delivery\$30.00
3. Consultant services involving major surgery, such as entrance into the abdominal cavity or cesarean section\$50.00

3. Pediatric Consultant Service

1. Bedside consultation\$ 5.00
2. Consultant services involving minor surgery\$10.00
3. Consultant services involving major surgery as described under Pediatric Surgery\$30.00

4. Bedside Nursing

Bedside nursing at time of delivery in home, or nursing care in home or hospital during a period of critical illness only, \$6.00 per eight-hour day and 75c per hour for additional time. Such care is limited to four successive days unless additional care is requested by attending physician.

5. Ambulance Service

When ambulance service is necessary and specifically requested by attending physician, it will be provided at \$1.50 loading charge and 30c per loaded mile.

6. Drugs, Services and Materials provided by the Physician

These may be included in the report and bill, if exact nature, amount and cost to the profession are given. X-ray service provided in attending physician's office may be included, but payment for any individual service may not exceed\$ 5.00

UNDER THE CAPITOL DOME

NEW TYPE STATE HOSPITAL URGED

Construction of a new state institution to hospitalize defective delinquents is being suggested as a postwar development by John H. Klinger, director of The Penal Institutions Division of the Indiana State Department of Public Welfare.

Mr. Klinger's suggestion grew out of observation of penal institution inmates over a period of years during which he has served in the welfare department. He explains, however, that the idea of such an institution is not original with him, as Illinois, New Jersey, New York, and other states already operate similar hospitals with successful results.

Study of the Indiana situation shows that there is a definite need for a hospital for defective delinquents in this state, he said. The state's penal institutions, the Indiana State Prison at Michigan City, the State Reformatory at Pendleton, and the Indiana Woman's Prison in Indianapolis all have inmates who should be removed to an institution which could provide the specialized care they need.

"Many of these prisoners are feeble-minded," Mr. Klinger explained, "and many of them have developed habits of delinquency. They may have developed those habits in their previous home or community environment, or they may have developed them since their incarceration, but the fact remains that they have these tendencies and habits.

"It is an important fact that they are easy tools of smarter delinquents, and are easily persuaded to do illegal acts. This may mean that they will thus violate prison rules, acting as a cat's paw for some unscrupulous, more intelligent prisoner; it may mean that, once turned back into their communities after serving their prison sentences, they will perform illegal errands or acts suggested by their former prison associates.

"Results of either type of action by these defective delinquents are obvious. While in the prisons they cause trouble for the officials and for themselves. On the outside, they simply get into fresh trouble and soon find themselves back behind prison bars. The net result, in either instance, is a loss of time and money to the state.

"If these prisoners were segregated and given the special type of treatment they need, they would be much better off themselves; the prisons would be better off; the community would profit."

If Indiana had such an institution, the courts would be able to sentence defective delinquents directly to it instead of to the state prison, reformatory, or woman's prison. Inmates would be considered patients rather than prisoners.

Generally speaking, according to Mr. Klinger, the patients who would be sentenced to the institution are incurable. He said he believes that certain types of epileptics also should be sent to this sort of an institution, and added that this is being done

in the states which now operate hospital-prisons for defective delinquents.

The experience of those other states, Mr. Klinger said, has been that under proper and specialized treatment some of the inmates can be safely released to society and successfully find places into which they fit, without giving any further trouble.

Some of the patients at the Indiana State School for Feeble-Minded Youth belong in a special hospital for defective delinquents rather than in the regular school, in the opinion of Mr. Klinger. As examples, he pointed out that there have been cases in which the feeble-minded persons escaped, and, once outside, attempted to wreck trains and set fire to buildings. Individuals of this type, by no means uncommon, belong in an institution with more stringent regulations and closer guarding than is necessary, and even preferable, for the general run of feeble-minded cases.

While it is true that many of the defective delinquents could profitably be sent to the already-established state hospital for the criminal insane, which is operated in conjunction with the state prison at Michigan City, there is not room for any additional patients there, and this plan automatically would be eliminated for that reason. That hospital has a capacity for 250 patients. It already is housing 340 patients. In addition, there are at least one hundred inmates at the reformatory who should be sent to the hospital for the criminal insane (not including the additional ones who should be sent to a hospital for defective delinquents if the state operated such an institution).

Mr. Klinger said the need for an institution such as he suggests unfortunately may be more necessary after the war than now, because some of the returned soldiers who have been injured in such a way that they have been affected mentally may need treatment and care of the type that could be provided.

VETERANS AT INDIANA STATE FARM

During the past four months men discharged from the armed forces during World War II composed 7.6 per cent of persons sentenced by Indiana courts to serve terms at the Indiana State Farm at Putnamville, according to a compilation of records in the State Department of Public Welfare. There were fifty-nine veterans out of a total of seven hundred and sixty men sentenced to the institution. A check of the records revealed that of the fifty-nine, twenty had been given medical discharges from the services.

The state farm receives persons convicted of minor offenses, for the most part, and men given short terms by the courts for more serious offenses. Of those received by the state farm, forty-one were discharged soldiers, fourteen discharged sailors, three discharged members of the Coast Guard, and one discharged from the Marines.

No similar records are yet available from the Indiana State Prison or the Indiana Reformatory.

Military News

Captain Aaron L. Arnold, of Indianapolis, who has been stationed at Chickasha, Oklahoma, has gone overseas.

We are informed that Dr. W. D. Britton, of Indianapolis, was recently promoted to a captain. He is stationed at Camp Ellis, Illinois.

Captain Leslie M. Baker, a member of the Delaware-Blackford County Medical Society, is now in northern Ireland, where he has been stationed since last October.

Captain Robert M. Butterfield, of Muncie, who is serving overseas, recently favored us with a V-Mail letter so as to insure delivery of his copy of THE JOURNAL and the "Hi Medico," as he terms it.

Captain H. C. Buhrmester, of Lafayette, has been promoted to a major in the Army Medical Corps. Major Buhrmester is stationed at Sioux Falls, South Dakota.

Major Horace M. Banks, of Indianapolis, who had been stationed at Fort Benning, Georgia, now has an A.P.O. address, indicating that he has been sent abroad.

Captain Richard S. Bloomer, of Rockville, formerly of Camp Atterbury, has been promoted to the rank of major and assigned to the 111th General Hospital, Fort Knox, Kentucky.

Lieutenant Commander Erwin Blackburn, of South Bend, delightfully surprised his family with an unexpected visit recently. He had received a new assignment and had returned from North Africa. Previously he had transferred from the Seabees to the Air Corps. Now it's Notre Dame.

Orchids to the St. Joseph County *Service Bulletin*, from Lieutenant W. D. Buchanan, of Bremen: "Received the Nov.-Dec. Bulletin this morning, and I think by far it is the best yet. (We love it.) The Bulletin has been of considerable interest to other medical officers in our group. They all wish they had the same service from their societies." He says he has been to a couple of nice parties in the last month; one was a barbecue of five wild boar, cooked over a grill; the other party was an Arabian dinner at the home of one of the near local gentry.

Captain Norman R. Carlson, of Michigan City, is now stationed at Camp Swift, Texas.

We have been informed that Captain Fred O. Clark, of Syracuse, has been transferred from Ellington Field, Texas, to Esler Field, Louisiana.

A Gary physician, Dr. Joseph A. Carbone, has been promoted to a major. He received his promotion in Italy, where he took part in the invasion of Salerno last September ninth.

Captain George Colip, of South Bend, arrived overseas in December and is located in a beautiful spot in England. He reported that living conditions are rugged, and conveniences are few; however, the food is excellent.

Two Peru physicians, Dr. R. E. Barnett and H. W. Eikenberry, are now stationed with the Medical Corps in Italy. According to reports, Dr. Barnett is with the Air Corps, and is seeing a great deal and enjoying it all. His specialty concerns oxygen therapy in high-altitude flying; he goes up with the plane crews to determine their reaction to the various altitudes.

Major Carl S. Culbertson, of South Bend, reported that the entire unit has been set up somewhere in England and that they are already functioning. Major Culbertson is quoted as saying that this war is particularly designed for gadgeteers, for many mechanical things are unattainable and much improvising has to be done. Food is abundant and of good quality. Tropical diseases have not as yet made their appearance among the troops that have cleared through the hospital.

"The first purpose of this letter is to advise you of my new address for the correction of your records," says Captain A. G. Blazey, who is stationed at a port of embarkation. (Let this be a reminder to all of you to keep us informed of your changes of address.) "I've been shipping out of this port as transport surgeon since last June and was given a permanent assignment last December.

"Secondly, I have enjoyed the group of 'MedSoc' letters that accumulate between trips at this address. They afford a tangible connection with the old life that would otherwise be broken. Keep them coming. Incidentally, I met a Kokomo physician in Casablanca last month. It was good to chat with someone from the Hoosier state."

According to the February two issue of the *Yank*, an Army magazine, Captain W. C. Stover, of Boonville, is now serving as a combat flight surgeon with the Army Air Corps, in England.

We have a report that Captain Casper Harstad, of Rockville, is now on duty in England. In civilian practice he was associated with the Indiana State Board of Health.

FIRSTHAND INFORMATION ON THE PANEL SYSTEM IN ENGLAND

England.

12 January, 1944.

DEAR SAM:

Your letter of December nineteenth arrived this morning, and as it happens that I have been intending to write you for some time, I'm going to "obey that impulse" right now. *The Bulletin* will indeed be welcome, for we all like to know what is going on at home and what is happening to the other men in service. To date I have been here in England a little more than two months, so am beginning to feel much less a stranger in a strange land than was the case at first.

We are located on the edge of a town on land which was once a golf course. At the club house I met an English doctor who is a very pleasant chap. He is retired from practice now, but when I was up to his rooms for cocktails on Christmas Day, I began asking questions about English medical practice under government control and the panel system. All I had to do was ask, and for about two hours he related incidents and practices showing up all of the evils which such a setup entails. He could scarcely find language adequate to condemn the whole thing, lock, stock, and barrel, and was very outspoken in stating that in his opinion the American people would be very foolish to trade the excellent care they have enjoyed under private medical practice for the shoddy, ponderous, and degrading system of state medicine. Specifically, his most telling criticisms of the system were as follows: It bound the individual doctor up so tightly in red tape—the filling out of forms, requisitions, et cetera—that he had little time to devote to the patient.

It put a progressive squeeze on the doctors' income because, as the administrative expense rose, the only place the money could come from within the budget was by cutting down on the cost of drugs and the amount paid the doctor per panel visit. At the present time the tax rate is nine shillings six pence (\$1.92) every six months per person, or less than four dollars per person per year.

The doctor, in order to make a living, has to see so many patients per day that he can not afford to spend more than a minute or two on each one. This, of course, precludes the possibility of any sort of physical examination.

Interesting or serious cases are not followed by the panel doctor, because once they enter a hospital they pass out of his jurisdiction and he no longer knows what happens to them.

The entire system tends to make of the medical man a sort of traffic cop—routing patients here or there instead of caring for them—and is definitely resulting in a deterioration in the quality and type of man attracted to medicine.

Last, but far from least, the control of the whole scheme is in the hands of politicians, and in order to get along one must court political favor or find himself harrassed constantly for minor infractions of the multiplicity of regulations and rules which bind the whole ponderous structure together. Definitely the picture is not a pretty one, and I hope that we in the States can by some means avoid any entry into the clutches of such a vicious system.

Please give my best regards to all the boys and assure them that I join in the hope that we can return before too long to pick up some of the burden.

Best regards for 1944. Write whenever you can find the time.

Sincerely,

MILLARD.

(The above is an excerpt from a letter sent to Dr. Samuel T. Miller, of Elkhart, by Lieutenant Commander J. M. Fleming, of Elkhart, who is now serving in England.)

Having served a year and a half in the European Theatre of Operations, Major William L. Porter, of College Corner, Ohio, has been returned to the U.S.A., and is now the executive officer of the Station Hospital at Fort Benjamin Harrison.

Lieutenant Commander A. F. Clements, of Evansville, is now aboard a hospital ship operating in the Pacific, where he is doing ear, nose and throat work exclusively. The ship carries a number of doctors, each a specialist in one field.

Captain D. D. Dickson, of Letts, is now supervisor of the Combat Crew Training School, at the Clovis Army Air Base, Clovis, New Mexico.

Lieutenant Arsenious R. Episcopo, of Mitchell, is now with the Mount Rainier Ordnance Depot, Office of the Surgeon, Tacoma, Washington.

We again have been favored with a copy of the St. Joseph County *Service Bulletin*, from which we glean numerous accounts of our members in the armed forces.

Captain Donald Grillo, of South Bend, is on temporary duty with a new hospital in China. So far he prefers China to India—living conditions are much better there.

Captain R. A. Gardner, of Michigan City, is now located at the State Hospital, Fort McPherson, Atlanta, Georgia.

Word has come to us that Captain Ted L. Grisell, of Mitchell, is at the Station Hospital, Camp Patrick Henry, Newport News, Virginia.

Major Leo L. Grzesk, of Mishawaka, who has been at Bowling Green, Virginia, now has a San Francisco A.P.O. address.

Captain W. G. Grosso, of East Chicago, is no longer at Camp Shelby, Mississippi, now having a New York A.P.O. address.

Major Gordon Haggard, of Columbus, is stationed at Camp Rapids, Rapid City, South Dakota.

Captain Orville A. Hall, of Muncie, who was formerly at Fort Benning, Georgia, is now stationed in the Caribbean Area.

The *Evansville Courier* of January nineteenth gives an interesting account of some of the experiences of our physicians in the armed forces. Although censorship permits only a few of their experiences to be related, some of the dangers and hardships they meet can be gleaned from communications received by relatives and friends. Captain Raymond N. Adler, who is serving as a transport surgeon in the Pacific Area, had reported on one occasion that a ship on which he was stationed had become stranded on some hidden obstacle. The crew and passengers nervously waited for dawn. By that time the tide had receded, and they found the defenseless boat clinging high on the side of a mountain. They could only wait and hope—yes, the tide moved back and the ship floated off.

According to word received by friends from Lieutenant E. A. King, of Evansville, he is now serving aboard a ship with the Pacific Fleet.

Captain Joseph E. Kopeha, of Whiting, received a promotion to major while in New Guinea, where he has been serving with the Fifth Air Force for the last six months.

According to word received by Mrs. Humphreys, Captain John W. Humphreys, of Darlington, is now a major. He is with the United States Army Medical Corps, in India, where he has been for the past eighteen months.

Captain Saimir Libnoch, of South Bend, is somewhere in Italy. It seems that he has seen Naples and Pompeii in his travels. He states that a bath or a haircut is quite a ritual in those parts—one stands in line and waits patiently for same.

An Evansville physician, Captain Jesse R. Logan, who was in Attu during the invasion of the island, recently visited with his family at Evansville. For the past nine months he was aboard a transport ship in the Northwest Pacific, but he is now acting as the head of the surgical division of an Army hospital in Canada.

Dr. Leonard Long, of Bluffton, has recently been promoted from captain to major in the Medical Corps of the Army of the United States, it has been announced at Fort Knox, Kentucky, by Colonel N. B. Briscoe, Post Commander. Major Long is the chief of X-Ray Service at the Station Hospital at Fort Knox, and entered the service on July 13, 1941.

The following V-Mail letter has been received from Captain Bennett Kraft, of Indianapolis, and will be of interest to his colleagues:

"I believe it is high time to throw off my writing laziness and inform the State Association of my whereabouts and doings. I am now in Italy, chief of Medical Service of a station hospital. Before coming here I spent eight months in Tunisia, and met quite a few Hoosiers: Major Daugherty, of Crawfordsville; Major Pence, of Columbia City; Captain Kidder, Fort Wayne; Major Palm, Brazil; Captain Voges, Terre Haute; and from Indianapolis, Major Herbert Sedam, Major Thomas Shields, and Captain Charles Maly. Captain S. S. Caplin left the area here the day I arrived and I did not get to see him. Give my best regards to your Journal staff. A few months ago we presented a symposium on the subject of 'Jaundice,' and I thought of Miss Rokke and her nice reference books which I could have used."

Major B. K. Zaring, of Columbus, has been transferred from Denver, Colorado, to the Station Hospital at Camp White, Oregon.

Lieutenant C. E. Muhlman, of LaPorte, is with the Letterman General Hospital, San Francisco, California.

Captain George Macy, of Columbus, has been transferred from Taft, California, to Denver, Colorado.

Captain Charles E. Moehlenkamp, of Evansville, who was formerly at Cleveland, Ohio, is now at Camp Perry, Ohio.

Training inspector for a Training Command is the duty of Captain Harry Pandolfo, of Indianapolis, who is now stationed at Lincoln, Nebraska.

Captain Gilbert D. Rhea, of Greencastle, has been transferred from Springfield, Missouri, to the Station Hospital at Camp Crowder, Missouri.

Lieutenant Leon J. Witkowski, of LaPorte, has been transferred from Marseilles, Illinois, to Fort Benjamin Harrison.

Lieutenant Colonel James W. McEwen, of Terre Haute, is now in charge of the Eye Section of the Eye, Ear, Nose and Throat Division at Camp Campbell, Kentucky.

A report released by a United Press staff correspondent, Albert Ravensholt, revealed that Captain Gerald S. Young, of Muncie, is with an air transport command carrying wounded and sick American fighting men back to secure hospitals in India. Among the twenty-five nurses working with the evacuation physicians happens to be a nurse from his home town, Muncie. She is Second Lieutenant Rosemary Albright. This proves that this is a small world after all.

While passing through Indianapolis on his way back to the Fitzsimmons General Hospital at Denver, Colorado, Lieutenant Colonel Robert A. Smith, of New Castle, paid us a visit. Colonel Smith is the Chief of the Eye, Ear, Nose and Throat Section at the Fitzsimmons Hospital. He reported that the following Indiana physicians were in that area: Lieutenant Colonel Roy L. Smith, of Indianapolis; Major Myers B. Deems, of Huntington; Major Walter A. Compton, of Elkhart; and Major Carl J. Rudolph, of South Bend.

"I have been receiving the copies of the 'MedSoc' letters since I have been in England, and I enjoy them very much," is an excerpt from a letter received from Captain Halden C. Woods, of Huntington. Incidentally, he also sent his new A. P. O. number so as to insure delivery of THE JOURNAL. May this serve as a reminder to others.

We are very grateful to Lieutenant Colonel David H. Sluss, of Indianapolis, for his very interesting letter, which we take the privilege of quoting herewith:

"It has been most pleasing and interesting receiving the communications from 'MedSoc,' and on numerous occasions I have intended to write a letter of appreciation. Only those of you who were far away from home during the last war understand the value of news from home, but even then, France was a good deal less foreign than Persia. While time does not permit sending answers to all those who wrote us greetings, I thought a word from Persia might be interesting to Miss Skinner. However, not knowing her address, but supposing you must have it in your correspondence files, I am sending it to you with the request that you forward it on for me.

"There is nothing of special moment concerning this command which I can write about because of censorship restrictions, except for a time there was a good deal of excitement when the conference was going on in Teheran. Those of us down here in the sticks knew there was something going on, but didn't know what until it was all over.

"Being as near to Turkey as to Russia we have, since the activation of this command, been expecting some move toward that country, but at the present time the flow seems toward India. There is a lot of betting as to the time Germany will fold up, and that time seems to mark the end of the serious part of the war for the majority of the troops in this command, and while most individuals think the German phase will be finished in a relatively few months, the Pacific phase is too nebulous to figure on. Those of us who have served in this country for more than a year are hoping we can come home for a few weeks at least before being assigned to some Pacific command, if and when we leave here. In spite of the difficulties of this country, climate, food, language, sanitation, etc., there are many interesting features. Not only have there been opportunities to travel up and down the length of Persia, but also I have visited Egypt, the Holy Land, Damascus in Syria, and ancient historical sites in Mesopotamia.

"Although the prices of Oriental rugs is absurdly high, with the inflation in full swing in Persia, we are learning the knack of bargaining with the merchants and are sending a few carpets home for souvenirs.

"Give my regards to those medical friends you run on to, and keep sending all the news you can."

News Notes

Dr. L. N. Geisinger and Mrs. Alma J. Dix, both of Auburn, were married at the Sacred Heart Hospital, in Garrett, on January fifteenth.

Dr. Everett W. Gaunt, of Indianapolis, and Miss Betty Lou Brown, of Franklin, were married in the First Presbyterian Church at Franklin, on January second. Dr. Gaunt, formerly of Indianapolis, has recently opened offices at Alexandria.

Dr. L. John Vogel, graduate of the Indiana University School of Medicine who recently completed his internship at the Methodist Hospital, in Indianapolis, has located at Mount Vernon for the practice of medicine.

Robert E. Lyons, M.D., who has been serving as a major in the United States Army, has re-opened his offices in Bloomington, where he will resume his private practice. He recently received a medical discharge.

Forty physicians attended the annual dinner given January thirteenth for members of the St. Joseph Hospital medical staff. The dinner was held at the St. Joseph Hospital in Logansport. The guest speaker was Commander Callahan of the Bunker Hill Naval Base.

Contributions to the post-war building project for the proposed addition to the Union Hospital at Terre Haute have reached a total of \$40,000, according to a report in the *Terre Haute Spectator*. It is believed that the amount will be doubled within a very short time.

Dr. James C. Katterjohn and Miss Patricia Ann Stayton, daughter of Dr. and Mrs. Chester A. Stayton, of Indianapolis, were married in the Sweeney Chapel at Butler University, in Indianapolis, on Sunday, January ninth. Doctor Katterjohn is a graduate of the Indiana University School of Medicine, and is practicing in Indianapolis.

POSTGRADUATE COURSE IN OCULAR SURGERY AND ORTHOPTICS

The seventh annual Postgraduate Course in Ocular Surgery, Pathology and Orthoptics, sponsored by The George Washington University School of Medicine, will be held at the Army Medical Museum, Washington, D.C., April 24 to 29, inclusive. For further information write to Miss Louisa Wells, 927 17th Street, N.W., Washington, D.C.

Dr. W. T. Lawson, of Danville, who is believed to be the oldest practicing physician in the United States, recently was confined to his bed, suffering from injuries to his back sustained in a fall. Doctor Lawson has served as secretary of the Hendricks County Medical Association since 1882, with the exception of three years when he served as president of the organization. He has also been the county health officer for many years. Indiana Medicine is proud of Dr. Lawson's record and achievements.

Another plea is being made by the Medical and Surgical Relief Committee of America for medical and surgical supplies; tarnished instruments, especially clamps, scalpels and forceps; surplus drugs; vitamins; infant foods, et cetera. Collected, packaged and sent to the Medical and Surgical Relief Committee, 420 Lexington Avenue, New York City, these items can play a vital role in its program of medical relief for the armed and civilian forces of the United Nations.

Dr. Carl H. McCaskey, of Indianapolis, topped his emancipation from the presidency of the Indiana State Medical Association by doing some post-graduate work in otolaryngology at the Los Angeles Research Study Club. Incidentally, we have learned that while there he did some hobnobbing with some of the movie actors. He was a guest of Dr. John P. Lordan, a former student at the Indiana University School of Medicine, who is now practicing ophthalmology in Los Angeles.

COLOR FILMS

A motion picture in color, "Continuous Caudal Analgesia in Obstetrics," is available for showing before medical societies and hospital staffs. It was made at the United States Marine Hospital, Staten Island, by authorization of the Surgeon General, United States Public Health Service, and the demonstrations were carried out by Drs. Hingson and Edwards, originators of the technic.

The three films that were made at the Nutrition Clinic of the University of Cincinnati, in the Hillman Hospital, Birmingham, Alabama, under the joint auspices of the Department of Internal Medicine at the University of Cincinnati and the University Hospitals of Cleveland, are likewise available for circulation. One of these deals with thiamin chloride deficiency, one with nicotinic acid deficiency, and the third with ariboflavinosis.

None of the films contain advertising. If you are interested in further information concerning these films, contact THE JOURNAL.

ANNUAL MEETING OF THE NORTHERN TRI-STATE MEDICAL ASSOCIATION

The Northern Tri-State Medical Association will hold its annual meeting at the Commodore Perry Hotel, at Toledo, Ohio, on Tuesday, April 11, 1944. The morning session opens at 8:30, Central War Time. The following program will be presented:

"Chemotherapy," Gordon B. Myers, M.D., Wayne University College of Medicine, Detroit, Michigan.

"Post-War Medical Problems Relative to Tropical Diseases," Robert A. Hettig, M.D., University Hospital, Ann Arbor, Michigan.

Round table discussion on "The Management of the Asthmatic," with Karl D. Figley, M.D., Toledo, Ohio, as moderator.

"Caudal Anesthesia," Henry Close Hesselstine, University of Chicago Lying-in Hospital, Chicago, Illinois.

"Diagnosis and Treatment of Medical Shock," M. A. Blankenhorn, M. D., University of Cincinnati College of Medicine, Cincinnati, Ohio.

"The Role of Biochemistry in the Etiology and Treatment of Cardiovascular Renal Disease," Nathan S. Davis, M.D., Northwestern Medical School, Chicago, Illinois.

"Diagnosis and Treatment of Ruptured Intervertebral Discs," Watler E. Dandy, M.D., Johns Hopkins Hospital, Baltimore, Maryland.

"Penicillin," Wallace E. Herrell, M.D., Mayo Foundation Graduate School, University of Minnesota.

CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE

The annual clinical conference of the Chicago Medical Society will be held at the Stevens Hotel, Chicago, on March 14, 15, 16, and 17, 1944.

PROGRAM

Tuesday, March 14

"Breast Tumors," diagnostic clinic, Alexander Brunschwig, M.D., Chicago; "Chronic Painful Feet," diagnostic clinic; "Amoebiasis and Dysentery," Walter L. Palmer, M.D., Chicago; "Value of X-ray in the Study of Postoperative Emergencies and Complications," James T. Case, M.D., Chicago; "Blood and Blood Substitutes," surgical panel, Lester Dragstedt, M.D., Chicago, Karl Meyer, M.D., Chicago, Sidney O. Levinson, M.D., Chicago, Garrott Allen, M.D., Chicago; "The Clinical Significance of Spontaneous Hemorrhage in Infancy and Childhood," Henry G. Poncher, M.D., Chicago; "Anesthetic Emergencies," Lieutenant W. A. Conroy, M.C., Gardiner General Hospital, Chicago; "Industrial Dermatoses," diagnostic clinic, Earl Osborne, M.D., Buffalo; "The Use and Abuse of Cesarean Section," Edward G. Waters, M.D., Jersey City; "The Employment of the Handicapped," Harold A. Vonachen, M.D., Peoria, Illinois; "War Neuroses—Their Rehabilitation and Absorption Into Industry," Lewis Pollock, M.D., Chicago; "Recent Advances in Endocrinology," Willard O. Thompson, M.D., Chicago; "Fears and Anxieties in Children," Bert I. Beverly, M.D., Chicago; "Penicillin," Donald G. Anderson, M.D., Boston; "This Thing Called Allergy," Dr. Karl D. Figley, M.D., Toledo; and "Differential Diagnosis and

Treatment of Ectopic Pregnancy," N. Sproat Heaney, M.D., Chicago.

Wednesday, March 15

"The Management of Acute Head Injuries," Paul C. Bucy, M.D., Chicago; "The Primary Management of Injuries of the Eye, Both Mechanical and Chemical," Glen W. Nethercut, M.D., Chicago; "Hematuria—Diagnosis and Treatment," Charles M. McKenna, M.D., Chicago; "Heart Burn," Walter C. Alvarez, Rochester, Minnesota; "The Use of Sulfonamides in Upper Respiratory Infections," Medical Panel, Brigadier General Hugh J. Morgan, Washington, D. C., and Italo Volini, M.D., Chicago; "Surgery of the Colon," Brigadier General Fred W. Rankin, United States Army Office of the Surgeon General, Washington, D. C.; "Eczema," diagnostic clinic, Edward A. Oliver, M.D., Chicago; "The Problem of the Obese Child," diagnostic clinic, I. P. Bronstein, M.D., Chicago; "The Clinical Aspects of Heart Block," Louis N. Katz, M.D., Chicago, and J. Roscoe Miller, M.D., Chicago; "Meningococcic Septicemia and Meningitis," Lieutenant Colonel Worth B. Daniels, Fort Bragg, North Carolina; and "Diagnosis and Treatment of Functional Uterine Bleeding," diagnostic clinic, Herbert E. Schmitz, M.D., Chicago, and Janet Towne, M.D., Chicago.

Thursday, March 16

"Management of Prolonged Labor," William C. Danforth, M.D., Evanston; "Bronchoscopy in Pulmonary Diseases of Childhood," Paul H. Holinger, M.D., Chicago; "Diabetes," diagnostic clinic; "Fractures" Kellogg Speed, M.D., Chicago, and William R. Cubbins, M.D., Chicago; "Urology," Herman L. Kretschmer, M.D., Chicago; "Rheumatic Heart Disease," Lieutenant Commander David H. Rosenberg, U. S. Naval Hospital, Great Lakes; "The Abuse of Sedatives in Medical Practice," Frederick P. Moersch, M.D., Rochester, Minnesota; "Some Aspects of the Tuberculosis Problem," Colonel Edmond R. Long, Army Service Forces, Office of the Surgeon General, Washington, D. C.; "Malaria," Lieutenant Colonel Charles M. Caravati, Chief of Medical Service, and Captain Robley D. Bates, Jr., Officer in Charge of Malaria Study, Percy Jones General Hospital, Battle Creek, Michigan; "Prevention and Treatment of Eclampsia," William J. Dieckmann, Chicago; "Peritonitis," E. W. Alton, M.D., New Orleans; "Trends in the Care of the Infantile Paralysis Patient," Herman C. Schumm, M.D., Milwaukee; Clinical Pathological Conference, Edwin F. Hirsch, M.D., Chicago.

Friday, March 17

"Obscure Abdominal Tumors: How the Roentgen Examination Can Aid in Their Diagnosis," Adolph Hartung, M.D., Chicago; "Surgical and Medical Management of Burns," Henry N. Harkins, M.D., Baltimore; "Gynecological Disorders Among Industrial Workers," H. Close Hesselstine, M.D., Chicago; "The Practical Side of Endocrinology," Roy G. Hoskins, M.D., Boston; "Effects of Drugs on the Blood," Roy R. Kracke, M.D., Atlanta; "Emergency Maternal and Infant Care—How It Affects the Doctor," Hugo V. Hullerman, M.D., Springfield, Illinois; "Complications of External Fixation of Fractures," J. Albert Key, M.D., St. Louis; "Fungus Infections of the Skin," J. H. Mitchell, M.D., Chicago; "Coronary Disease," Drew William Luten, M.D., St. Louis; and "Cause of Reactions in Blood Transfusions," I. Davidsohn, M.D., Chicago.

We must beware of trying to build a society in which nobody counts for anything except a politician or an official, a society where enterprise gains no reward and thrift no privileges.—Winston Churchill.

INDIANA UNIVERSITY NEWS NOTES

Army General Hospital No. 32, made up of doctors and dentists of Indiana recruited under the sponsorship of the Indiana University Medical Center and now stationed in England, has received the commendation of Major General John C. H. Lee, commanding the service of supply of the United States Army in the European theater, and of Brigadier General Paul R. Hawley, chief surgeon of the same command.

Dean W. D. Gatch of the Indiana University School of Medicine has received through Colonel Cyrus J. Clark, former Indianapolis physician and medical school faculty member, who commands the hospital, copies of the letters of commendation written by Generals Lee and Hawley. The former, after making an inspection of the Hoosier unit, made this report:

"Never expecting less than the highest standards from the Medical Corps, it is none the less gratifying to find things so well in hand."

General Hawley, a native of West College Corner, Indiana, who received his A.B. degree from Indiana University in 1912, made this additional comment:

"The Chief Surgeon is very proud of Indiana University's 32 General Hospital. The medical service of the European Theater of Operations has a very high standard. That you have met that standard so soon after your arrival in this theater is evidence of the fine personnel and the fine leadership of your organization. You are proper Hoosiers, and your Chief Surgeon is one Hoosier who is proud to be a fellow citizen of yours."

The unit was commissioned in June, 1942, assigned for training at Camp Bowie, Texas, and has been stationed for several months in England. The nurse personnel of the unit has been assigned to other overseas service.

Dr. Lowell T. Coggeshall, Indiana University graduate, who is now one of the world's foremost authorities on malaria, has been named medical director of tropical disease rehabilitation and training program for the Navy on the west coast. From 1935 to 1940, Dr. Coggeshall was in charge of malaria research for the Rockefeller Foundation in New York, and in 1940 he joined the faculty of the University of Michigan and will be on leave of absence there while serving with the Navy.

A native of Saratoga, Indiana, Dr. Coggeshall received his A.B. degree from Indiana University in 1922, the A.M. degree the following year, and the doctor of medicine degree in 1928.

Shortly after going to the University of Michigan, Dr. Coggeshall was called to Africa to establish tropical disease control measures for the air ferry route through that continent and the Middle

East into China. He returned to Ann Arbor, became chairman of the department of tropical diseases, and continued his research program. In his new post Dr. Coggeshall will be medical director of a large Navy research center devoted exclusively to study and treatment of malaria.

"We're going to try to cure men infected with the parasite as rapidly as possible," Dr. Coggeshall said, "and will concentrate on developing new and more effective treatment methods."

At present, Dr. Coggeshall pointed out, there is no certain cure for malaria. Neither quinine nor atabrin, two drugs used extensively by military forces, cure the disease, but both "suppress the symptoms" and relieve the patient's discomfort. However, he explained, if dosage of the drugs is halted, the symptoms return. Thirty-seven per cent of those infected with malaria suffer recurrent attacks and never are entirely free of the disease, although many persons have enough natural resistance to throw off malarial infection, according to Dr. Coggeshall.

Drug research, including work with atabrin, began about three years before the war, Dr. Coggeshall said, and thousands of drugs have been tested. "If a shortage of both quinine and atabrin should develop," he declared, "we already know what we would use. There is little danger that we will run out of effective drugs."

"Although this disease has resulted in very few deaths among our service men, it has made thousands ill and is one of the world's major medical problems," Dr. Coggeshall said.

Dr. Coggeshall's brother, Howard, was graduated from the Indiana University School of Medicine in 1932 and is now a captain in the Medical Corps at Camp Carson, Colorado. He also has another brother, Warren, who is a pre-medic student at Indiana University.

Dr. William H. Headlee, head of the Division of Tropical Medicine and Parasitology of the Indiana University School of Medicine, has been selected to make a study of tropical diseases in Central America. The selection of Dr. Headlee was made by the Association of American Medical Colleges. The study will be financed by the Markle Foundation in cooperation with the Army Medical Corps as one of the precautionary measures being taken to prevent introduction and spread of tropical diseases in this country by returning members of the armed forces.

Dr. Headlee will leave the United States in March and will conduct his studies in Guatemala, Honduras, and Costa Rica.



Deaths

DIED IN MILITARY SERVICE



• Captain Miller

Captain Harry D. Miller, of Shelbyville, was killed in an accident while serving with the United States Army Medical Corps, in Algeria, on February second. He left Shelbyville May 15, 1942, and was the second Shelbyville physician to enter the service in World War II. He was stationed at San Antonio, Texas; Fort Sill, Oklahoma, and Camp Barkley, Texas, before going overseas, and had been in Africa since November, 1942, being chief of the medical staff at a station hospital in Algeria. He was thirty-six years of age.

Captain Miller graduated from the University of Illinois College of Medicine, Chicago, in 1934, and limited his practice to Internal Medicine.

Captain Miller was a member of the Shelby County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Volney Fackler, M.D., who had practiced in Richmond for the past fifteen years, died suddenly at his home on February first. He was seventy-one years of age. Doctor Fackler graduated from the University of Medicine, Indianapolis, in 1907. He was a member of the Wayne County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Alexander M. Kan, M.D., of Gary, died at a local hospital on January thirty-first, at the age of sixty-two years. He was a graduate of the Illinois Medical College, Chicago, in 1906, and had practiced in Gary for thirty years. He served as a captain in the Medical Corps during World War I. Doctor Kan was a member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Charles S. Goar, M.D., of Indianapolis, died on February fourth at the age of seventy-eight. He graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1888, and had practiced medicine for fifty-two years. A few years ago he was honored at a dinner of the Indianapolis Medical Society as being the oldest practicing physician in Indianapolis. He retired from active practice three years ago.

In 1896 Doctor Goar was elected as joint senator for Tipton and Hamilton counties, and served as chairman of the Committee on Public Health in the 1897 and 1899 sessions, when the Medical Registration Law was enacted.

Doctor Goar was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Hugh A. Cowing, M.D., of Muncie, one of Indiana's pioneer physicians and health authority, died at a local hospital at Muncie on February ninth, following an illness of several months. He was eighty-three years of age at the time of his death. Doctor Cowing was a graduate of the Miami Medical College, Cincinnati, in 1890. He served as president of the Indiana State Board of Health in 1921-22, and had been a member of the Muncie Board of Health most of the time since 1892. He was also secretary of the Delaware County Board of Health for twenty-three years.

Doctor Cowing was an author and lecturer, having contributed several scientific articles to various medical publications, and was the author of "A Meandering Hoosier," a story of his travels, with many poems and sketches.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

January 8, 1944.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; F. T. Romberger, M.D.; E. M. Shanklin, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Membership Report

Number of members Dec. 31, 1943	3,336*
Number of members Dec. 31, 1942	3,260
Gain	76
Number of members Jan. 8, 1944	537

*Includes 127 honorary members and 921 military members.

Treasurer's Office

The financial statement for 1943 was discussed by the treasurer. This report will be presented before the midwinter meeting of the Council and will be published in THE JOURNAL.

The statements of receipts and expenditures for December for the association committees and THE JOURNAL were approved.

Recommendations to Council

Recommendations of the Executive Committee to the Council on organization of the Indiana State Medical Association to carry out mandates of the House of Delegates discussed, prepared, and approved by the committee.

1944 Annual Session, Indianapolis, October 3, 4 and 5, 1944

Report received from Dr. C. E. Cox, treasurer of the Murat Temple, that perhaps arrangements can be made for the Murat Temple.

Dr. Bert Ellis, chairman of the Committee on Convention Arrangements, is to have report ready for the Council meeting.

Commercial exhibit. Floor plan to be mailed in February.

Legislative, Legal and Social Security Matters

National

Copies of A. M. A. Legislative Bulletin No. 29 distributed to members of the committee.

Status of Wagner-Murray-Dingell Bill—still remaining in committee.

a. Dr. Morris Fishbein to speak at Howard County Medical Society meeting January 18, 1944, upon postwar planning, socialized medicine, and the Wagner-Murray-Dingell Bill.

b. Arrangements made for "School for Speakers" at annual Secretaries' Conference January 23,

1944, approved by committee. As the chairman of the Council will not be present, the president-elect is to preside in his place.

c. The committee approved a letter from the State Chamber of Commerce to be sent to physicians.

d. The committee approved sending a "MedSoc" letter dealing with the Wagner-Murray-Dingell Bill to the men in service.

e. Page from *The Union*, local labor paper, boosting the bill, brought to the attention of the committee.

f. "Anent the New Wagner Bill," article by Felix J. Underwood, M.D., health officer in Mississippi, giving authority to statement by Tom Parran that he was not consulted in regard to the bill and that the bill was introduced without his consent, brought to the attention of the committee.

g. Copy of *The Shelbyville Republican*, containing advertisement against bill and letter from Dr. Paul Tindall, brought to the attention of the committee.

h. Letter from the Indiana State Nurses' Association and reply from Senator Walter F. George, reading as follows, brought to the attention of the committee:

"I cannot support this bill as it was introduced, and I am not sure that we are ready to take any further step in extending the Social Security System at this time. I assure you the matter will not be hastily approved by the Senate Finance Committee."

The committee feels that the letter to the Nurses' Association is of great value as it develops a new point of view in regard to this bill.

Rehabilitation of lay veterans. a. Dr. Dean A. Clark, surgeon of the United States Public Health Service, has been appointed chief medical officer of the Office of Vocational Rehabilitation "to take charge of the newly-established Physical Rehabilitation Section of the War Manpower Commission. . . . Federal funds for remedial medical treatment of the physically handicapped was authorized for the first time under the Barden-LaFollette Act of July 6, 1943."

b. Letter from J. D. Ferguson, president and editor of *The Milwaukee Journal*, in regard to rehabilitation of veterans of World War II, brought to the attention of the committee.

All matters in regard to rehabilitation are to be taken up with the Committee on Industrial Health of which Dr. E. S. Jones is chairman.

Public Relations

Formation of separate medical organizations. Western States Public Health League and Association of American Physicians and Surgeons, Inc., (Lake County), discussed by the committee.

Letter from Dr. Olin West, secretary of the American Medical Association, and Dr. Romberger's answer, in regard to the remarks made at the recent meeting of the House of Delegates of the Indiana State Medical Association, brought to the attention of the committee.

"Indiana Contact Plan" approved and distributed to the various states by the Council on Medical Service and Public Relations of the American Medical Association.

Comments on the "Pearl Harbor" issue of THE JOURNAL of the Indiana State Medical Association, which contained resolutions passed by the House of Delegates in regard to public relations and a Washington office of the A. M. A., brought to the attention of the committee. Among these comments is a letter from Dr. Frank Lahey and also a letter from Dr. William F. Braasch, member of the Board of Trustees of the A. M. A.

Organization Matters

Committee appointments for 1944 by Dr. Oliphant published in January 1944 JOURNAL. Several committees were discontinued and, where possible, functions of various committees were combined.

Notice received by the committee that the Fort Wayne Medical Society has brought action against a physician for unethical practice.

Question of election of a councilor for the Twelfth District brought to the attention of the Executive Committee. It was the opinion of the committee that any action having to do with the election of a councilor was a matter for the Council to determine in the final analysis, that is, if the matter cannot be determined within the district itself.

War Medicine

Status of men serving in the United States Public Health Service. The following question and answer from the War Manpower Commission were brought to the attention of the committee:

"Why is the Public Health Service classed as one of the branches of the Armed Forces as far as medical officers are concerned?"

"For many reasons, among them the fact that it supplies the medical personnel for the United States Coast Guard. Physically qualified eligible officers are assigned by the Public Health Service for active duty with the Coast Guard and may be assigned anywhere the American flag flies."

The Oregon State Medical Society is laying plans to help physicians when they leave military service. This matter is to be brought up for further discussion at the next meeting of the Executive Committee.

Letter received from the secretary of the Greene County Medical Society, which reads as follows in regard to the plan for medical care of infants and wives of men in the armed services:

"Because of the dissatisfaction of members of this society with the complex nature of this plan and the tendency of the government to regulate and set fees for this service, it was voted not to continue further and enter into any more contracts for this service.

"The contracts already signed by members of this society will be completed and fully carried out, but effective December 16, 1943, no further contracts of this nature will be signed by any member of this society."

Socialized Medicine

Reply to article that appeared in *The Teachers College Journal*, by Wilbur Brookover, former instructor in Social Studies at Indiana State Teachers College, discussed by the committee. Dr. Oliphant presented his answer, which was approved by the committee. This is to be sent to *The Teachers College Journal* of the Indiana State Teachers College.

Group Hospitalization and Voluntary Health Insurance

The following excerpts from minutes of past meetings of the Executive Committee in regard to group hospitalization and medical service plans were brought to the attention of the committee:

"From minutes of August 10, 1941 meeting:

"Group Hospitalization and Medical Service Plans

"Visit from heads of Michigan Hospital Service. John R. Mannix, head of the Michigan Hospital Service, and Mr. Griffin, attorney for Michigan Hospital Service, paid a visit to Indiana and proposed that a hospital service plan be set up in this state immediately and without waiting for a legislative enabling act. The Executive Committee was of the opinion that the medical profession would not oppose such a plan if it were presented by the hospital association, but that the state medical association would actively sponsor a plan only after the proper clauses, which, according to the Attorney General's opinion are necessary to make such plans legal in this state, were written in the law."

"From annual report of Executive Committee to the House of Delegates, 1942 session:

"Hospital Association advocates preparing hospitalization bill. The Indiana Hospital Association is working on a hospitalization plan which it hopes may be put into effect without any further legislative action. It is the opinion of the Executive Committee that the medical profession would not be opposed to the proper hospitalization plan (the medical association generally sponsored such a plan several years ago in cooperation with the hospital association) if such a plan were presented by the hospital association. The state association, however, feels

that it would sponsor actively such a plan only if the plan, according to the attorney general's opinion, would be legal in this state. Numerous meetings have been held by members of the Executive Committee with representatives of the Indiana Hospital Association, Miss Nellie Brown and Clarence Hess, together with John R. Manix, head of the Michigan Hospital Service."

Dr. Nafe and Dr. McCaskey reported that the hospital association is considering the formation of a mutual hospital insurance company which will meet the provisions of the Blue Cross Hospital Plan, and that they had been asked to serve as members of the board of directors of this company. The committee approved of Dr. Nafe and Dr. McCaskey sitting in on these meetings and reporting back to the committee at its next meeting.

Letters from a psychiatrist in regard to the covering of mental diseases in hospital insurance plans brought to the attention of the committee. The committee suggested that this material be taken up with the hospital committee.

Material from the West Virginia State Medical Association in regard to the Blue Shield (non-profit) Medical-Surgical Service Plan, which is operating in West Virginia, brought to the attention of the committee. This is to be forwarded to Dr. W. H. Howard, chairman of the Permanent Study Committee on Health Insurance.

Medical Relief

Letter from Dr. Alfred Ellison in regard to problems concerning medical relief brought to the attention of the committee, and it was suggested that Dr. Ellison discuss these matters with the Council. The basic question follows: "Is it good principle to pay the physician direct rather than to pay the patient and have the patient pay the physician when State or Federal funds are involved?"

Drs. C. S. Black of Warren, Eugene Boggs of Indianapolis, and Alfred Ellison of South Bend, have been appointed to serve on the Advisory Committee to the State Department of Public Welfare, and Dr. Ellison said it was their desire to know the feeling of the medical profession in regard to this question in order that the desires of the profession may be adhered to.

Future Medical Meetings

January 23, 1944—Secretaries' Conference, Indianapolis.

January 30, 1944—Secretaries' Conference of Michigan State Medical Society, Detroit.

February 13, 1944—National Conference on Medical Service, Chicago.

May 4-5, 1944—Indiana Industrial Health Conference, Indianapolis. (Tentative.)

June 12-16, 1944—A. M. A. meeting, Chicago.

Medical Defense

The Army has ruled that physicians are subject to malpractice charges for services rendered while

they are in the Army. Insurance companies are asking that physicians in the Army keep up their malpractice insurance because of this ruling. Several complaints have come to headquarters' office that this is an added burden on the physician in service or on the families of physicians whose insurance agents call, recommending that these policies be kept in force.

Group malpractice insurance. Dr. Nafe made a report to the committee upon the survey in regard to group malpractice insurance for members of the association. He said that four companies had expressed their interest, and following interviews with the representatives of these companies, a report would be made to the next meeting of the Executive Committee, upon which it might act.

There being no further business, the meeting was adjourned.

COUNTY SOCIETIES

COUNTY MEDICAL SOCIETY OFFICERS

DAVIESS-MARTIN COUNTY MEDICAL SOCIETY:

President, Ira E. Bowman, Odon
Vice-president, Karl Helm, Shoals
Secretary-treasurer, C. P. Fox, Washington

DEARBORN-OHIO COUNTY MEDICAL SOCIETY

President, E. P. Droham, Lawrenceburg (In Service)
Vice-President and Acting-President, G. S. Fessler, Rising Sun
Secretary-Treasurer, J. C. Elliott, Guilford

MIAMI COUNTY MEDICAL SOCIETY:

President, F. M. Lynn, Peru
Vice-president, R. E. Wildman, Peru
Secretary-treasurer, E. Lee Burrows, Peru

MORGAN COUNTY MEDICAL SOCIETY:

President, M. C. Pitkin, Martinsville
Secretary-treasurer, K. L. Dickens, Martinsville

WELLS COUNTY MEDICAL SOCIETY:

President, Robert C. Wybourn, Ossian
Vice-president, Harold D. Caylor, Bluffton
Secretary-treasurer, H. Brooks Smith, Bluffton

LOCAL SOCIETY REPORTS

100% IN PAYMENT OF 1944 DUES

Bartholomew County
Benton County
Dearborn-Ohio Counties
Hancock County
Hendricks County
LaGrange County
Marshall County
Orange County
Pulaski County
Putnam County

Bartholomew County Medical Society members held a business meeting at the Chamber of Commerce Building, Columbus, on February second, the retiring and incoming presidents being the dinner hosts. Seven members were in attendance.

Daviess-Martin County Medical Society members met at the home of Dr. B. O. Burress, Washington, on January twenty-fifth. Doctor Burress is confined to his home because of an injury, so the members met at his home in order that he could be with them. This was a business meeting and officers were elected for 1944. Thirteen members attended the meeting.

Dearborn-Ohio County Medical Society members held a business meeting at the Aurora Public Library, on January twentieth. Officers were elected for 1944 and a discussion was held concerning current matters. Seven members were in attendance.

Elkhart County Medical Society members met on February third at the Hotel Elkhart. The program consisted of a review of the "Autobiography of Dr. Alice Hamilton" by Miss Grace McNutt, and a report on the Secretaries' Conference by Dr. O. E. Wilson, Secretary of the Society. Fifty-one members and guests attended the meeting, the Woman's Auxiliary being guests of the Society.

Floyd County Medical Society members held a meeting at New Albany on January fourteenth, 1944, with eleven members in attendance. The speaker of the evening was Dr. A. P. Hauss, of New Albany, who gave a report on the Proceedings of the Council.

Grant County Medical Society members met at the Marion General Hospital on January twentieth. They were entertained by Major John A. Ritchey, of Marion, who told of his experiences while in Australia in the service of his country. Fifteen members attended the meeting.

Hamilton County Medical Society members held their meeting at Noblesville, January twentieth. Officers were elected for 1944 and an extensive discussion was held concerning "socialized medicine."

Howard County Medical Society members met at the St. Joseph Memorial Hospital, Kokomo, on February fourth. Dr. R. A. Craig, of Kokomo, spoke on "Congenital Anomalies of the Abdomen." Nineteen members were present at this meeting.

Indianapolis Medical Society members held a meeting at the Indianapolis Athletic Club on February first. The following case reports were presented: "A Case of Intussusception in a Girl Twenty-one Years Old," by Dr. R. M. Vandivier; "Scarlet Fever," by Dr. Lee Brayton; "Multiple Myeloma," by Dr. Robert Taylor; "Sprained Ankle," by Dr. R. L. Keenan; and "Malaria," by Dr. J. C. Katterjohn.

On February eighth a demonstration was given by officers of the Functional Medical Department Enlisted Technicians' School, Fort Harrison, in regard to the training of medical laboratory technicians. The assistant commandant of the school was in charge of the meeting.

At a meeting held on February fifteenth the program consisted of a symposium held on "Leg Ulcers," Dr. C. L. Rudesill being the moderator and Drs. Russell Lamb, H. M. Trusler, C. K. Hepburn, H. C. Thornton, and T. D. Rhodes taking part in the discussion.

On February twenty-second Dr. K. K. Chen spoke on "Natural and Synthetic Products of the Digitalis Group," and Dr. R. M. Moore presented "Some Clinical Indications for Digitalis Therapy."

At a meeting held February twenty-ninth, Dr. Don Bowers and Dr. H. J. Weil discussed "Anesthesia and Analgesia in Office Practice," Dr. John Spahr spoke on "Ureteral Catheter Instillation Technique in Caudal Analgesia," and Dr. H. O. McCormick presented "Continuous Caudal Analgesia in Obstetrics Used in One Hundred Cases." A discussion followed by Drs. C. F. Gillespie, C. P. Huber, and D. C. Hines.

LaPorte County Medical Society members held a meeting at the Spaulding Hotel, in Michigan City, on January twentieth. Dr. A. Jerome Sparks, of Fort Wayne, spoke on "Upper Urinary Tract Symptoms of General Interest," illustrated by a number of x-ray films. Twenty-six members attended the meeting.

Montgomery County Medical Society members met on January twentieth at Crawfordsville. Captain Lent C. Johnson, of Billings General Hospital, spoke on "Recent Advances in Malaria," describing his experiences with cases returning from the Southwest Pacific. The meeting was attended by seventeen members.

Parke-Vermillion County Medical Society members held a meeting at the Parke-Vermillion County Hospital, Clinton, on January nineteenth. Dr. Hubert B. Pirkle, of the Indiana Tuberculosis Sanatorium at Rockville, spoke on "Pulmonary Tuberculosis." Eleven members attended the meeting.

Putnam County Medical Society members met at Greencastle on December fourteenth for their annual Christmas dinner.

On January thirteenth a meeting was held which was attended by eleven members and one guest.

Four members and one guest attended the regular meeting held February tenth.

Spencer County Medical Society members met at Rockport on January nineteenth. The program was devoted to a general discussion, and all present officers were re-elected for 1944. Seven members attended the meeting.

(Continued on page xxiii)

(Continued from page 168)

St. Joseph County Medical Society members held a meeting at the Indiana Club, South Bend, on January twenty-fifth. The program consisted of a talk by Dr. Grant E. Metcalfe on "Alcoholics Anonymous" and a motion picture film on "Lesions of the Cervix" was shown by Dr. R. B. Sanderson, of South Bend. The meeting was attended by twenty-nine members.

Wells County Medical Society members met at the office of Dr. G. B. Morris. The meeting was held to elect officers for 1944.

COUNCILOR DISTRICT REPORT

Twelfth District Medical Society Meeting

On January eighteenth the Chamber of Commerce Building in Fort Wayne was the scene of the Twelfth District Meeting for the year 1944. Dr. Walter Kruse of Fort Wayne, Vice-president of the District, was in the chair in the absence of the President, Dr. Ben Pence of Columbia City, now with the United States Army in Africa.

The scientific portion of the program was presented by the Medical Detachment of the nearby United States Army Post, Baer Field. Major Mosko was chairman of this section of the meeting. "Tropical Medicine" was the theme of the papers read, the laboratory as well as clinical aspects being presented. Following the formal portion of the program a general discussion of the topics was entered into by various members.

Dr. A. J. Sparks, Fort Wayne, was elected Councilor for the District. The other officers installed were Dr. Harry D. Brickley, Bluffton, President; Dr. Scudder Welty, Fort Wayne, Vice-president; Dr. Emor Cartwright, Fort Wayne, Secretary-treasurer.

INDIANA ROENTGEN SOCIETY

At a meeting of the Indiana Roentgen Society, held in Indianapolis, January 30, 1944, the following resolution in regard to hospital insurance was unanimously adopted:

"WHEREAS, it has been definitely established both by legal decisions in many states and by action of the House of Delegates of the American Medical Association that the practice of radiology is the practice of medicine; and

"WHEREAS, the practice of medicine by a corporation or the sale of medical services by a corporation is regarded generally and by the medical profession as unethical and in many states is definitely illegal; therefore, be it

"RESOLVED, That the Indiana Roentgen Society here records its opposition to the inclusion of the radiological services in any proposed hospital serv-

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MEDICINE—Two Weeks Intensive Course Internal Medicine starts June 19. Two Weeks Course Gastro-Enterology starts June 5.

GYNECOLOGY—Two Weeks Intensive Course starting April 3 and June 12. One Week Personal Course Vaginal Approach to Pelvic Surgery starting April 17.

OBSTETRICS—Two Weeks Intensive Course starting April 17 and June 26.

ANESTHESIA—Two Weeks Course Regional and Intravenous Anesthesia.

GASTROSCOPY—Personal Course starting April 3, June 19, and October 16.

OTOLARYNGOLOGY—Two Weeks Intensive Course starting April 3.

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ice insurance contracts, and requests the members of the committees of the Indiana State Medical Association now engaged in designing such contracts to bend their efforts to the effect that radiological services be not included in any such contracts; and be it further

"RESOLVED, That a copy of this resolution be inscribed upon the records of this society, and that copies be sent to the Indiana State Medical Association, the Indiana Association of Pathologists, and to the secretaries of each of the County Medical Societies making up the Indiana State Medical Association, and to the Indiana Hospital Association."

WOMAN'S AUXILIARY
to the
Indiana State Medical Association

President—Mrs. James Baxter, Jr., New Albany
President-elect—Mrs. F. M. Gastineau, Indianapolis
Corresponding Secretary—Mrs. John Habermel, New Albany
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis

Again it is our pleasure to welcome a new auxiliary to our organization. Clark County (Jeffersonville) has very recently been organized. The officers are: President, Mrs. R. G. Burman; President-elect, Mrs. C. F. C. Hancock; Vice-president, Mrs. A. P. Buckley; Secretary-treasurer, Mrs. J. T. Carney.

Mrs. James Baxter, president of our state organization, writes that she visited the Vanderburgh County Auxiliary, in Evansville, on January twelfth. We quote, "They certainly had a wonderful day arranged. Mrs. Habermel, the corresponding secretary, went with me. We attended a luncheon and board meeting at 1:00 P.M. at the McCurdy Hotel, and a lovely tea from 3:00 to 5:00 at the home of Mrs. Mell Wellborn. In the evening we attended a bridge party given by the Dr's. Mrs. at the Vendome Hotel. The Dr's. Mrs. is a part of their auxiliary for the younger wives. This is the part of the organization that takes care of the Army doctors' wives there at Camp Breckenridge, the Marine Hospital, and the three or four defense plants they have in the city. The regular auxiliary meets for luncheons, and the younger ones get together for night bridge parties. Of course, there is some overlapping of membership."

HOWARD COUNTY

Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, talked on the "Wagner-Murray-Dingell Bill" before an audience of over four hundred and twenty-five on January eighteenth at the Memorial Hall of the Howard

County Court House. This was a public meeting, sponsored by the Howard County Medical Auxiliary, and was broadcast over Station WKMO. Mrs. G. N. Druley, president of the Auxiliary, opened the meeting, and Miss Lucy Schuler, program chairman, introduced Doctor Fishbein.

Prior to the meeting the Howard County Medical Society entertained with a stag dinner at the St. Joseph Hospital. Sister Calista and Sister Theca of the staff were responsible for a delicious buffet dinner. Among the guests were Walter Bennet, president of the A. F. of L.; J. O. Finley, representing the C.I.O.; Dr. Raymond Walker, of the Howard County Dental Society; Dow Richardson, of the *Kokomo Tribune*; W. W. Dragoo, chairman of the Republican party; Claude Gordon, chairman of the Democratic county party; Forrest Addington, auditor of Howard County; Robert Hamp, clerk of the Circuit Court; Virgil Fleenor, president of the School Masters Club; and Dr. H. G. Hamer, Dr. Carl McCaskey, and Thomas Hendricks of Indianapolis.

Dr. Fishbein assailed the bill as "a medical dictatorship which would destroy the high quality of medical care in this country."

"If medicine comes to be a function of the state, it will be only a short step to state control of travel, food, employment, and every facility under which we live," he warned. "Therefore, it is up to all citizens to see that no one group of people is enslaved lest all groups lose the right of free enterprise on which our democracy is based."

Dr. Fishbein pointed out the great progress that medical science is making in its unregimented way, and stated that better medical service is reaching more people constantly and that improvement for the masses would continue to come through such evolvement rather than by an overnight change of system, such as is proposed by the Wagner-Murray-Dingell Bill.

Under the provisions of this bill a patient not satisfied with the choice of the physician assigned him would have to pay to get another doctor, and thus his medical expense would be greater because he had paid for the first doctor through the compulsory tax which would support the federal program. "Where would the working man save any expense under those circumstances?" he asked. "We enjoy the highest standards of living—and of medical care—in the world. Under state medicine this quality of service would decline because physicians would need no individual initiative."

Compulsory sick insurance is used in England and Germany. "You have only to read Hans Fallada's *Little Man, What Now?* or Richard Lewellyn's *How Green Was My Valley* to see how the worker is buffeted about from bureau to bureau trying to get medical care," he said. "In Fallada's book the hero goes to the state-maintained medical bureau for aid for his wife, who is about to become a mother. His child is two years old before he gets the red tape of the social bureaucrats unraveled."

Dr. Fishbein pointed out that the American Medical Association is not opposed to various groups of citizens banding together through insurance plans for protection against sickness and hospital bills. This idea is rapidly growing in America. But he stressed the fact that it is still on a voluntary basis.

"Many doctors are working on salaries," Dr. Fishbein said, and he estimated that 20 to 25 per cent of the nation's doctors are salaried men. The medical profession is not opposed to this. The physicians working in the great clinics of this country work for a salary, but the patient has the right to choose his own clinic.

Dr. Fishbein said that medical aid will be extended on a vast scale throughout the country in the next few years, with hospitals and health centers being built in increasing numbers close to the communities of low income workers. "But this extension must move forward on the basis of individual initiative if we are to maintain our American democracy," he added.

American Medicine is constantly striving toward high achievement and has extended life expectancy twenty years since 1890, greatly reduced the death rate in childbirth, and is making phenomenal gains against cancer, pneumonia, meningitis, venereal disease, and other ailments. "The United States Public Health Service is spending large sums to control venereal disease by tracking down those who carry it," he said; "however, it is the advancement of medical science that

will control the disease. Penicillin can change a Wassermann test from positive to negative in two weeks, and sulfa drugs can arrest gonorrhea in two days."

The people would have to pay for their medical service through increased taxes under this bill. There would be a withholding tax up to 6% on earnings up to \$3,000 a year, and an additional six per cent of payrolls from the employer, he explained. This bill is just part of the trend in the government to enter into people's lives, the speaker said. "Right now the American people are beginning to feel that the government is a little too much for us," he added.

In 1929 when we were in the midst of a depression, the government began to take care of citizens by formation of the Social Security Program. Not one doctor of any standing is a member of the Social Security Board which is studying what should be done in a medical program that would be approved by Congress, he said.

There are fifty-five thousand doctors in the armed forces, and Doctor Fishbein urged that it would be unfair to expect them to return after the war and find themselves slaves of a medical dictatorship.

In closing, Doctor Fishbein said that the freedom of America has been represented in one way by the average man's freedom to choose his own doctor for matters which deal intimately with his life—that the choice is his own affair and not that of Washington.

Books

- BOOKS RECEIVED
- HANDBOOK OF NUTRITION.** A Symposium, Prepared Under the Auspices of the Council on Foods and Nutrition of the American Medical Association. 586 pages. Cloth. Price \$2.50. American Medical Association, Chicago, 1943.

ESSENTIALS OF DERMATOLOGY. By Norman Tobias, M.D., Fellow, American Academy of Dermatology and Syphilology; Diplomate, American Board of Dermatology and Syphilology. Second edition. 497 pages with 143 illustrations. Cloth. Price \$4.75.

SAFE CONVOY. The Expectant Mother's Handbook. By William J. Carrington, M.D., F.A.C.S., Diplomate of the American Board of Obstetrics and Gynecology; Former Vice-president of the American Medical Association. 256 pages. Cloth. Price \$2.50. J. B. Lippincott Company, Philadelphia, 1944. Copyrighted, 1944.

An actress congratulated Ilka Chase on her recent book, *Past Imperfect*. "I enjoyed it," she said. "Who wrote it for you?"

"Darling," clawed Ilka, "I'm so glad you liked it. Who read it to you?"—Walter Winchell.

—Reader's Digest.

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

	Jan. 1944	Dec. 1943	Nov. 1943	Jan. 1943	Jan. 1942
DISEASES					
Pulmonary Tuberculosis	250	300	128	106	147
Tuberculosis, Other Forms.....	3	37	40	7	24
Chickenpox	387	222	314	383	377
Measles	1085	460	407	738	214
Scarlet Fever	451	239	265	453	516
Smallpox	2	3	9	49	14
Typhoid Fever	47	3	2	6	8
Whooping Cough	81	92	111	109	222
Diphtheria	61	32	67	27	50
Influenza	573	2431	65	78	210
Pneumonia	80	42	26	210	104
Mumps	120	74	115	291	124
Poliomyelitis	6	0	2	5	6
Cerebrospinal Meningitis	65	25	13	22	3
Nonepidemic Meningitis	1	1	0	0	0
Trachoma	1	0	1	1	0
Malaria	37	1	3	0	0
Tularemia	5	5	2	10	9
Rubella	65	120	8	701	6
Undulant Fever	2	3	5	1	2
Impetigo	3	0	0	0	0
Dysentery (Unclassified)	2	0	0	0	0
Noninfectious Encephalitis	1	0	0	1	0
Trichinosis	1	0	0	0	0
Infectious Jaundice	1	0	0	0	0
Vincent's Angina	1	0	1	25	0
Food Poisoning	6	0	0	0	0
Typhus Fever	1	0	0	0	0

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\$50.00 weekly indemnity, accident and sickness	per year
\$15,000.00 accidental death	For \$96.00
\$75.00 weekly indemnity, accident and sickness	per year

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY *under Direction of the Council*

OFFICE OF PUBLICATION: 1021 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

APRIL, 1944

NUMBER 4

CANCER PREVENTION

DON D. BOWERS, M.D.

INDIANAPOLIS

Humane, social and economic needs for more effective cancer control are continually and indelibly impressed upon the minds of members of the medical profession. No arguments are needed to support a program aimed at the prevention of suffering and untimely death. The social value of women during the child-bearing and family-raising period is as self-evident as the economic value of the prevention of male deaths during the time of their greatest productivity.

There are those outside our profession, some of great power, who are apparently not wholly conscious of the existence and the importance of this greatest hazard to life on earth. Preferring to become enthused in accumulating huge reserves of funds to support health efforts of little importance to society and in initiating experimental changes which markedly affect the economics of all of us, this group of benefactors, along with all other educated people, should have their humanitarian interest directed to useful purposes, such as cancer control.

In recent years the cancer control program has been admirably pursued by the American Society for the Control of Cancer through the associated Women's Field Army and the medical profession. The object has been to educate the public concerning the nature of cancer, the more frequent and obvious signs which might indicate a threat or existence of cancer, and the necessity for early treatment of such conditions. The campaign slogans, such as "Early Cancer is Curable," are familiar to us all. Such efforts have done immeasurable good. Patients with accessible cancer and conditions preceding cancer in accessible areas are presenting themselves for treatment earlier than in the past. Early diagnosis of cancer of the skin, lips, mouth, and breast is relatively simple and treatment is very effective. Continuing efforts against these forms may bring them under practical control.

Such a result will be accomplished in direct proportion to the enthusiasm and effort that individual physicians put into the program. All physicians should aid the Cancer Committee of the Indiana State Medical Association in its program to initiate and carry on local diagnostic cancer clinics. The object of such clinics is to conduct examinations to detect early cancer, precancerous lesions, and cancer-forming habits and diseases. The physicians of every community in the state should organize and operate such a project, aided by the local organization of the Women's Field Army.

Curative medicine, utilizing developments in diagnosis, surgery, and radiation as applied to the field, may gain a strangle-hold on external or accessible types of cancer, being aided by educational programs already initiated, yet there is little evidence to indicate that the incidence and mortality rate of deep-seated cancer is being affected. The educational campaigns have had little or no effect upon cancer of the internal organs because such efforts are based upon early diagnosis, which is often impossible. These forms of the disease have not been made more curable by improvements in diagnostic, radiation, or surgical methods.

The late Dr. James Ewing¹ stated, "If the campaign against cancer seriously proposes to effect a substantial reduction in the mortality from this group of diseases, efforts may not be confined to the pursuit of fundamental problems of cancer by scientific laboratory methods, but must approach the subject from a broad practical standpoint and include prevention in the scope of its activities."

Various types of cancer are known to be preceded by local deviations from normal tissue physiology. Although in many instances the exact transition into cancer process has not been proved, clinical

¹ Pack, G. T., and Livingston, E. M.: *Treatment of Cancer and Allied Diseases*, 1:4. Hoeber, N.Y., 1940.

experience dictates that cancer usually does not become initiated in normal tissue, and the processes frequently seen before the cancer exists have become known as exciting factors.

Whether the recognized exciting factors are sufficient to form the fundamentals upon which an effective campaign for cancer prevention may be built remains to be proved. No such organized program has been attempted to date. Ewing expressed the belief that such a program is urgently needed and might be very successful in certain types of cancer.

The physician must constitute the unit about which the structure of such a campaign is built, and the factors generally accepted to excite various forms of cancer must be familiar to him.

More complete and widely-distributed educational brochures with plain facts concerning cancer and arguments for periodic examinations should be placed in the hands of every intelligent American. Such a program is not revolutionary, exciting, or apt to attract a spectacular immediate response. Preventive medicine has never been accomplished easily and must be persisted in to bring results.

A brief consideration of the abnormal processes which may initiate cancer of various organs, and considered by Ewing and others to be of importance, may prove timely.

MAMMARY CANCER

Main causes are chronic cystic mastitis and stagnation of milk or other secretions, alone or combined. The prevention of breast cancer is related to the control thereof.

Tumors and infection of isolated gland islands occur more frequently in individuals with oily skin and overdevelopment of the sweat or apocrine glands. Poorly-developed, depressed nipples may predispose to cancer with stagnation.

Chronic mastitis, as evidenced by periductal fibrosis, isolated or multiple widely-distributed cysts and ductal distention in young women, has been successfully treated with heat, massage, and breast pump by Keynes and Adair. Some cases require excision of locally affected areas; others require radiation therapy of the breast and/or ovaries.

Nipple bleeding requires proof that cancer does not exist. The underlying cause is usually papillary adenoma of the ducts or cancer. Adair found that 50 per cent of the breasts with bleeding nipples were cancerous.

Scars of old incisions into the breast may harbor cancer, and the tight brassiere produces stagnation and is condemned, as is also the modern practice of suppressing lactation. A history of normal lactation was elicited by Adair in only 8 per cent (16) of 200 cases of mammary cancer.

We often elicit history of breast cancer occurring in related individuals, which dictates careful attention to the breasts of other relatives, since heredity may predispose to cancer of this organ. Madge T. Macklin, of Canada, stated that the chances, on the basis of chance alone, of four or

five related individuals developing the same type of cancer is no greater than the chance of being dealt a perfect hand of cards, or approximately one in 157 billion hands.

SKIN CANCER

Many and variable specific entities are included in this group. Their major control problem consists of obliteration of precancerous neoplastic lesions (moles and keratoses) and the early eradication of active cancer.

The free use of soap and water prevents uncleanness, stoppage of sebaceous and sweat glands, and stagnation with infection—factors preceding many skin cancers.

Light-sensitive individuals with easily-disturbed pigment metabolism should be protected from the sun, wind, and from excess heat and cold.

The prolonged irritation of inflammation and infection, as from tuberculosis, syphilis, eczema, old burn scars, and infection in sebaceous cysts are potential hazards.

Pigmented moles exposed to trauma or irritation should be excised with special care, since they often give rise to the most-rapidly fatal skin cancer, malignant melanoma. Changes in color, size, bleeding, or growth of hair indicate activity within benign pigmented lesions, and dictate immediate treatment. Incomplete eradication by inexperienced individuals is the most frequent cause of failure to control the extension of pigmented lesions.

Single, isolated "warty" growths appearing on the hands, feet, or mucous membranes of an adult are usually non-pigmented melanoma or epithelioma, and as such should be regarded as dangerous.

CANCER OF THE ESOPHAGUS AND STOMACH

Ewing believed that the important predisposing factors constitute abuses of these organs. Such conditions as dental disease with improper mastication of the food, irregularity of meals, and lack of water.

CANCER OF THE LIP, MOUTH, AND TONGUE

The accepted causes of these forms are more widely known even to the laymen: irritations from hot pipestem, cigars, excessive cigarette smoking, leukoplakia, fissures, keratoses, decaying teeth, and burns from heat, chemicals, or sunlight.

Poorly-fitting denture and amalgam fillings and plates produce irritation, and the dental profession must actively cooperate in any cancer prevention program.

Abuse of tobacco and the voice are chiefly responsible for cancer of the larynx, and as a rule the victim is forewarned by long-standing hoarseness.

CANCER OF THE RECTUM

Polypoid growths sometimes precede cancer of this organ, but no satisfactory proof exists of other exciting causes. Earlier diagnosis seems to date to

constitute the chief hope for reduced mortality, which up to the present time has been very high.

CANCER OF THE UTERINE CERVIX

The main problem is one of control of cervical lacerations and infections. Ample facilities exist for the treatment of these conditions.

Cervical cancer occurs in child-bearing women, just as mammary cancer occurs in the nonlactating. It seems that women are "between the Scylla of cancer of the cervix if they do, and the Charybdis of cancer of the breast if they do not."

Long-continued warnings concerning the dangers of irregularities of bleeding, especially menopause bleeding, have failed to appreciably lower the incidence of this type of cancer. Some physicians have failed to appreciate the value of the vaginal speculum and direct inspection of the cervix, vagina, and vulva. Leukoplakia, infections, and precancerous growths should be eradicated.

INTERNAL ORGANS

Stones lodged in the gall bladder, prostatic, pancreatic, and salivary gland ducts and urinary bladder seem responsible for some cancers of these organs. Stagnation of the prostate precedes cancer, and chronic infection of the lung may influence the development of lung cancer.

INDUSTRIAL CANCER

Simple cleanliness and proper ventilation will eliminate major hazards in industry.

GENERAL PREDISPOSING CAUSES

Heredity figures in neurofibromatosis, melanoma, chondroma, and mammary cancer. Ewing believed that heredity is of little importance in gastric and intestinal cancer, but the dietary habits in families probably outweigh the hereditary factors.

PERIODIC HEALTH EXAMINATION

In periodic health examination seems to be the possible solution of the cancer-prevention problem today—careful education in and search for factors indicating cancer, precancerous lesions, habits and diseases which are known to predispose to cancer.

Cancer-control publicity should be so intensified and modernized as to reflect the definite opinion of authorities that much can be done which may prevent cancer of internal organs in the individual. The necessity for periodic examination by the physician naturally follows.

The physician must possess knowledge of the exciting factors and conditions known to precede the various forms of cancer. He must preach individual hygiene in this relation, and the importance of moderation in eating, drinking, exercise, and avoidance of exposure to all forms of irritation. Above all, he must inculcate the need for that godly quality, "cleanliness," the liberal use of soap and water, which is probably *the best single preventive of preventable cancer*.

Such a program would be unspectacular and hardly what the public has been led to expect in regard to cancer prevention, but is probably more closely related to cancer control than a very scientific exposé.

When individuals generally realize that cancer constitutes the greatest single threat to their own lives; that, generally speaking, this situation is becoming more serious for them individually and the danger greater rather than less, all educated persons will anxiously seek out whatever advice our profession can give relative to cancer control. This is another responsibility which must be met by the medical profession.

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ABSTRACTS

WARN OF MALARIA DANGER AMONG THOSE RETURNING FROM TROPICS

Pointing out that certain types of malaria, such as falciparum, may be difficult to recognize due to the wide variety of symptoms, Harry Most, M.D., and Henry E. Meleney, M.D., New York, warn in *The Journal of the American Medical Association* for January 8 that "Every passenger and crew member of an airplane returning from a malarious region should be instructed to obtain medical attention on the first development of any symptoms of illness, even those of a common cold. . . . Every patient returning from the tropics should have a thick and thin blood smear examined for malarial parasites, and if negative this should be repeated every twelve to twenty-four hours until malaria is confirmed or excluded. . . ."

WARNS THAT INFLUENZAL MENINGITIS IS POTENTIALLY CONTAGIOUS

A warning that influenzal meningitis is a potentially contagious disease despite general beliefs to the contrary is contained in a report in *The Journal of the American Medical Association* for February 19 by A. J.

Hertzog, M.D.; Isabell Logan Cameron, M.D., and A. E. Karlstrom, M.D., Minneapolis.

The three physicians report the cases of two brothers fatally stricken with the disease. The older, aged four years, died within twenty-six hours after onset of the disease and the younger, aged two years, became ill two days later and died within fifteen hours.

"These cases," the authors say, "show that it is possible to have more than one child in a family contract influenzal meningitis and that the disease is potentially contagious. If other young children are present in a family where influenzal meningitis has occurred, prophylactic doses of sulfadiazine or passive immunization would seem indicated. . . ." They explain that according to a previous investigator the incubation period of the disease is less than five days.

"The method of spread of influenzal meningitis," the Minneapolis physicians explain, "is not well understood. The usual sporadic nature of the disease suggests carriers as a possible source of infection. In our cases, nose and throat cultures taken by the Minnesota Department of Health from parents and other contacts were negative for *Haemophilus influenzae*. The tendency to affect infants and young children almost exclusively suggests that the average adult is immune to the disease. . . ."

USE OF HORMONES IN DISEASES OF WOMEN*

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To obtain good results from replacement therapy, we must first possess an active hormone of adequate strength. Need for the substance must exist, and the tissues must be capable of responding physiologically. Estrogens are the most valuable female sex hormones because they are available in adequate strength at practical cost; need for them can be accurately demonstrated; and conditions frequently exist in which the body responds normally to their administration. The clinical importance of progesterone is increasing as dosage is better understood and the cost is lowered. Physiologically, these two hormones complement each other. Progesterone does not work to advantage without estrogen, and for greatest benefit progesterone must act on tissues prepared by estrogen. In the management of many menstrual disorders estrogen should be given both previously to and simultaneously with progesterone.

Tropic hormones have been disappointing. They are too weak, too costly, and/or the tissues do not respond well to them. A definite need for tropic hormones is difficult to define. Denegrative changes may occur in the end organ, or antihormones may form. Clinicians do not treat myxedema with thyrotropic hormone or Addison's disease with adrenotropic hormone.

Gonadotropic hormones from the pituitary gland or pregnant mare's serum offer hope for production of ovulation. In certain otherwise healthy young women in whom the ovary is near the point of response, ovulation may follow injection of these hormones. It takes the energy of the enthusiast to search out the good results of gonadotropins. More critical and less enthusiastic observers remain unimpressed. Although theoretically chorionic gonadotropin produces a luteinization, this action has not been conclusively proved in the human female, and its clinical usefulness is largely empiric. Estrogens and progesterone cannot stimulate the ovary, and gonadotropins probably cannot stimulate the pituitary. Gonadotropins are just as truly replacement therapy as ovarian hormones, and upon withdrawal the same deficiency state may be expected as existed previously. In some cases an adjustment apparently is reached, and a permanent effect follows. Prolonged use of estrogens in large doses may have a severely depressive action upon the ovaries. The proper time of administration of female sex hormones is as important as the dosage.

In discussing hormonal therapy of diseases of women, proper emphasis should be placed upon the general health with reference to nutrition, including the use of iron and extra vitamins, and to

treatment of infection and tumors, especially of the ovaries or pituitary gland. Thyroid therapy is frequently beneficial.

In determining the degree of ovarian deficiency, methods of great value are vaginal smear studies and endometrial biopsies. Both can be done quickly in the office. We prefer the Novak curet and find that less fragmentation of specimens occurs if suction is omitted. The technic of the tests and their interpretation are easily learned and will yield objective data, which are very helpful in applying proper therapy. Most irregularities of menstruation are associated with some ovarian deficiency; however, amenorrhea may be entirely uterine in origin, and menorrhagia may be associated with a variety of endometrial patterns. Endometrium taken previous to or within twelve hours of the beginning of a period will indicate the response of the corpus luteum and provide good presumptive evidence for or against ovulation. A normal endometrium before menstruation implies that ovulation has occurred; a subnormal response suggests the possibility of intrinsic abnormalities of the endometrium.

Sterility. When sterility is associated with absence of ovulation, as shown by the premenstrual endometrial pattern and vaginal smears, gonadotropins may be tried, provided other factors have proved normal. Such factors as normality of the sperms, cervix, uterus, and tubes must be considered in detail. We prefer to use pituitary gonadotropic factor, 300 units daily for 10 days preceding the calculated ovulation time, and chorionic gonadotropin, 500 units daily for 7 to 10 days following this date. Extract of pregnant mares' serum may be used in place of pituitary extract. It usually appears that the ovary responds little, if at all, or only temporarily. When the deficiency is mild, pregnancy may follow treatment.

Pathologic amenorrhea is usually due to ovarian deficiency. Distinct clinical or roentgen evidence of pituitary disease is rarely found in amenorrhea. Definite thyroid disease is also an uncommon cause. More frequently associated obesity, hirsutism, hypertension, and a tendency for polycythemia and diabetes suggest an adrenal factor. Amenorrhea of psychic origin is relatively common. In a combination of psychic and nutritional causes, as in anorexia nervosa, no hormone therapy is needed.

Amenorrhea of uterine origin not infrequently is treated as primary ovarian failure. Breast development, the vaginal size, and vaginal smear are normal. The uterus, however, is small, and the endometrium poorly developed, suggesting a congenital etiology. Cyclic steroid therapy, however, may be used to produce cyclic bleeding, if indicated.

* Read before the General Meeting at the ninety-fourth annual session of the Indiana State Medical Association, at Indianapolis, September 29, 1943.

Ideal therapy in amenorrhea would produce ovulation monthly and a normal endometrium prepared for nidation. Anticipation of such results represents optimistic faith, perhaps complementary to clinical endocrinology but not born of experience. One of several practical reasons for therapy may exist: (1) to produce anatomic development of vagina, breasts, and secondary sex characteristics; (2) to treat associated menopausal symptoms which may occur at any age from sixteen to sixty; (3) for the psychic effect of recurrent bleeding.

These effects can be obtained by the cyclic use of estrogens and progesterone. Estrogen is given from a theoretic day no. 1, for twenty-four days. Progesterone may be given in three to five injections over the last six to ten days of estrogen therapy. Estrogen builds up the endometrium, and progesterone has a maturing effect. Upon withdrawal of both, bleeding usually follows promptly in three or four days and is more limited, as a rule, when progesterone is used than when omitted. On the first day of bleeding a second course may be initiated. The dose of estrogen may be determined from observation of vaginal smears.

There are many effective preparations for therapy from which to choose. Stilbestrol in doses of from 0.5 to 2.0 mg. a day orally may be effective. Estrone may be used intramuscularly in doses of 1.0 to 2.0 mg. (10,000 to 20,000 I.U.) three times weekly. The dosage of estradiol benzoate is 0.33 mg. (2,000 rat units) intramuscularly three times weekly. Progesterone may be used in three to five injections of 5.0 to 10.0 mg. each. Probably larger doses should be used. In place of progesterone 10 mg. per day of pregnenolone (pranone) for ten days may be tried.

Stilbestrol has the obvious advantages of oral administration and low cost. However, nausea or other so-called toxic reactions occasionally occur and sometimes can be avoided by using small doses initially, enteric coated tablets or one of the special preparations, or by giving the drug at bedtime. If disturbing side effects are to be avoided with certainty, natural estrogens should be used, and the disadvantages of injections and of somewhat greater cost accepted. The oral use of natural estrogens may be indicated where smaller doses are needed. Despite toxic effects of stilbestrol, serious damage with moderate doses is seldom if ever seen. Estrogens are contraindicated when cancer or reasonable suspicion of cancer of the reproductive system exists. Despite suspicion, estrogens have not been shown to be a cause of carcinoma in women.

Menorrhagia. In menstrual irregularities, including menorrhagia, endometrial studies signify that in the majority of cases some degree of hypoplasia of the endometrium exists. This may vary from mild luteal deficiency to severe lack of both follicular and luteal hormone. A persistent follicular effect may occur, or there may be irreg-

ular ripening and shedding of the endometrium associated with irregular follicular and luteal development.¹ Sometimes no endometrial disturbance is present. Where abnormalities do exist, it may be questionable whether there is simply a lack of hormones or a poor endometrial response. If regulation of bleeding is the primary aim of therapy, the simplest and most effective measures may be the cyclic use of steroids as previously outlined.

Some cases may be treated to advantage in a different manner. Adolescents often respond to daily doses of 1000 international units of chorionic gonadotropin for eight to ten days preceding and during the flow. If repeated for several months, such therapy will regulate approximately 75 per cent of the cases, and permanent relief may be expected in more than half. Small doses of testosterone propionate, such as 10 mg. twice weekly, may be effective. At or near the climacteric the problem differs; the danger of cancer is greater; and curettment is desirable for diagnostic purposes. At the time of operation 600 to 800 milligram hours of radium may be applied. Some cases require further radiation, which can be given as roentgen therapy later.

If biopsy reveals an endometrium which shows persistent or excessive estrogenic effect, such as the "Swiss cheese" endometrium or metropathia hemorrhagica, progesterone alone may be indicated. A preliminary curettage may be desirable, or 50 mg. of progesterone given over a period of seven to ten days and stopped abruptly may produce what Albright² has termed medical curettment. In such cases the repetition of 15 to 25 mg. in three to five doses preceding each period may produce relatively normal flow. Pregnenolone (pranone) orally in ten doses of 10 to 20 mg. each may be effective.

The immediate control of menorrhagia may be difficult. In severe cases uterine packing, immediate curettment, or transfusion may be necessary. In less severe cases bleeding may stop promptly following the injection of relatively large doses of estrogens or of testosterone propionate. Estradiol benzoate 0.66 mg. to 1.7 mg. daily or twice daily, estrone in equivalent doses intramuscularly, or stilbestrol given every 15 minutes to an hour may be tried. We have usually used not more than 5.0 mg. per day, but very much larger doses may be used. Some workers use 10.0 mg. or more every 15 minutes until bleeding stops. If testosterone is used, 50 mg. of the propionate daily is usually sufficient. Not more than 300 mg. per month should be used. Also, a combination of treatment may be chosen, including rest, sedation, pituitrin, ergot, moccasin venom, and a program of hormonal ther-

¹ Traut, H. F., and Kruder, A.: Irregular Shedding and Irregular Ripening of Endometrium, *Surg. Gynec. & Obst.*, 61:145-154, (Aug.) 1935.

² Albright, F.: Metropathia Hemorrhagica, *Maine M. J.*, 29:235-238, (Nov.) 1938.

apy as outlined previously. When hormonal treatment fails, hysterectomy may be preferable to radiation castration if the patient is young.

Dysmenorrhea of the congestive type responds little, if at all, to hormonal therapy. Spasmodic dysmenorrhea (functional) in many instances responds remarkably well to large doses of estrogens. Sturgis and Albright³ advise the use of 1.7 mg. of estradiol benzoate every three days for six injections, beginning not later than the sixth day of the cycle. Approximately the same result can be obtained by giving 1.0 to 1.5 mg. of stilbestrol orally, daily, from the fifth to the fifteenth day of the cycle. In some cases pelvic pain occurs regularly in the intermenstrual period (*mittelschmerz*) and can be controlled in a similar manner. In two of my cases three injections of chorionic gonadotropin timed to precede the known date of the intermenstrual pain prevents it if used regularly. In both dysmenorrhea and *mittelschmerz*, pain recurs the next month if therapy is discontinued. Such therapy apparently prevents ovulation, and in its judicious use this consideration must be kept in mind.

Premenstrual edema. Some degree of generalized edema is very common before the menstrual flow is established. It is often associated with nervous disturbances and can be well treated, according to Greenhill and Freed,⁴ by the limitation of sodium chloride intake and the administration of ammonium chloride in the second half of the menstrual cycle. Severe degrees of this condition with marked cerebral edema and choked disc are occasionally seen. Thomas's⁵ cases and ours appeared to obtain relief from chorionic gonadotropin used empirically. Ivy's⁶ case appeared to respond to emmenin. In our severe cases we also use strenuous limitation of sodium chloride and water plus the administration of as much as 12 gm. potassium nitrate in enteric-coated tablets per day.

Premenstrual tension frequently exists to a pathologic degree for years before the climacteric is evident. Its response to adequate amounts of estrogen alone or with progesterone given during the second half of the cycle suggests that it is hypovarian in origin.

Climacteric. The treatment of the change of life is usually simple and usually resolves itself into the judicious use of psychotherapy, sedatives, and sufficient estrogens. If a minimum of estrogen is

given, there seems to be a chance for earlier psychologic adjustment than if large doses are used persistently. Symptomatic control is usually the only requirement. In separating psychoneurotic symptoms from hormonal ones, the vaginal smear will show when a full physiologic response to estrogens is being obtained. The danger of producing menorrhagia by treatment can be avoided, as a rule, by withdrawal of therapy for a week each month. Occasionally menorrhagia and menopausal symptoms occur together, and male hormone may be used to advantage, minimizing the necessity for estrogen. Methyl testosterone in doses of 10 mg. orally, daily, or 10 mg. of testosterone propionate two or three times weekly may be helpful. Doses of this size cannot be expected to produce masculinization. Abnormally-heightened libido of the menopause can usually be controlled with estrogens, and conversely libido can be stimulated by the use of male hormone, but usually this will not occur unless it existed normally previously.

Senile vaginitis. True senile vaginitis is not common. When irritation of the atrophic vaginal mucosa produces symptoms, careful treatment for eradication of existing infection or diabetes is essential, and simple measures of cleanliness and mild antiseptics may be sufficient. If not, generous doses of estrogen will usually be beneficial.

Habitual abortion. The recognition of the fact that early removal of the corpus luteum of pregnancy is followed by abortion appears reasonable proof that progesterone deficiency is one cause of habitual abortion. Such factors as uterine abnormality, syphilis, and an abnormal response to the fetal development of Rh. factor must not be overlooked. Sperm abnormalities may be to blame in some cases. In the absence of other obvious abnormality, relatively large doses of progesterone are indicated during the first four months of pregnancy. Perhaps a dose of 10 mg. per day, as suggested by the studies of pregnandiol excretion, may be sufficient, but present ideas of dosage may need further revision. Here again the effectiveness of progesterone is enhanced by estrogen. The idea that estrogens may cause abortion can, I believe, be completely discounted. The usefulness of iodine or thyroid should not be overlooked.

Cystic disease of the breast. In many instances of diffuse adenosis of the breast, mastalgia recurs premenstrually. Estrogens commonly ameliorate this condition. Small doses, such as 0.24 mg. of estriol daily during the last half of the cycle, may be helpful. In more severe breast engorgement, male hormone may be used. In this regard the value of testosterone propionate has been well demonstrated in preventing or inhibiting lactation. Approximately four daily doses of 25 to 50 mg. each may be expected to cause prompt cessation of lactation. Whether or not estrogens have a curative effect on cystic disease of the breast has not been demonstrated.

³ Sturgis, S. H., and Albright, F.: Mechanism of Estrin Therapy in Relief of Dysmenorrhea, *Endocrinology*, **26**:68-77, (Jan.) 1940.

⁴ Greenhill, J. P., and Freed, S. C.: Mechanism and Treatment of Premenstrual Distress with Ammonium Chloride, *Endocrinology*, **26**:529-531, (Mar.) 1940.

⁵ Thomas, W. A.: Generalized Edema Occurring only at the Menstrual Period, *J. A. M. A.*, **113**:234-236, (July 28,) 1934.

⁶ Atkinson, A. J., and Ivy, A. C.: Menstrual Edema; Case Controlled by Emmenin but not by Theelin or Theelin, *J. A. M. A.*, **106**:515-517, (Feb.) 1936.

Hirsutism. Stilbestrol has been reported as having been curative in hirsutism,⁷ but this experience has not been common. In rare instances excessive hair growth in women may be the result of testic-

⁷ McCullagh, E. P.: Menstrual Edema with Intracranial Hypertension, *Cleveland Clin. Quart.*, 8:202-212, (Oct.) 1941.

ular tumors of the ovary (arrhenoblastomata) or of adrenal tumors. In such cases improvement may follow surgery. In most instances the cause of excessive hair growth in women cannot be shown by any known means. It must be treated by depilation or shaving, and there is no endocrine cure worthy of the name.

PANCREATIC CYSTS*

With Report of Two Unusual Cases

ELI SHERMAN JONES, M.D.

HAMMOND

Although the literature on the subject of pancreatic cysts is replete with statements to the effect that these lesions are rare, my colleagues and myself have found, in our limited experience, one case undiagnosed until autopsy and nineteen operable cases—all with favorable prognosis. In view of the fact that Walters and Cleveland¹ have reported a frequency of but one case of pancreatic cyst in eight thousand registrations, covering a period of five years at the Mayo Clinic, it would seem that our frequency is unusual.

Connolly² reported a case of pancreatic cyst in a child aged fourteen months. Railton³ found a pancreatic cyst in an infant six months old. Eha⁴ reported a case in an infant but five months old. These were all congenital cysts.

The two cases which we report here may be considered of special interest from a diagnostic point of view in that one case was a congenital tumor of the pancreas, found in a four-year-old child, presenting typical symptoms of a ruptured appendix with diffuse, spreading peritonitis; and the other case, established only at autopsy, was a degenerative pancreatic cyst extending into the mediastinum and rupturing into the right pleural cavity.

There are various classifications of pancreatic cysts. Thigpen⁵ classifies them as follows: 1. Pseudocysts, without epithelial lining, which may be the result of trauma or of inflammation. 2. Retention cysts resulting from obstruction to

the outflow of secretion by calculi or pancreatitis. 3. Neoplastic cysts, which may occur in the cystadenoma, a cystadenocarcinoma, a sarcoma, or a teratoma. 4. Cysts resulting from defective development. 5. Parasitic cysts such as the hydatid variety. Archibald and Kaufman⁶ have grouped them thus: 1. Adenocystoma, true pancreatic cysts lined with cuboidal epithelium. Usually ferments are absent in the cystic fluid. 2. Retention cysts, the result of obstruction of one of the smaller pancreatic ducts due to calculi, tumor, or scar tissue. These cysts are small and are associated with interstitial pancreatitis. 3. Degenerative cysts, the end results of localized acute pancreatic necrosis with softening and cystic transformation of the destroyed pancreatic tissue. They occur within the substance of the pancreas. 4. Pseudocysts, etiologically and morphologically similar to degenerative cysts, but occurring outside the main body of the pancreatic substance, usually in the lesser peritoneal sac. They may contain blood, inflammatory exudate, and small amounts of pancreatic fluid.

Pseudocysts are without an epithelial lining and may be the result of trauma or inflammation. Morgagni⁷ described multiple cysts of pancreas, omentum, and mesentery in a cadaver in 1791. Claessen,⁸ 1842, stated that the treatment for pancreatic cysts should be of the symptoms as they arise, and diet. LeDentu,⁹ 1862, said that he had treated what he thought to be a cyst of the liver by puncturing it and draining it, but that the patient died of peritonitis. It proved to be a pan-

* Read before the Section on Surgery of the Indiana State Medical Association, at Indianapolis, September 29, 1943.

¹ Walters, Waltman, and Cleveland, William H.: Surgical Lesions of the Pancreas, *Archives of Surgery*, 42:819-838 (May) 1940.

² Connolly, D. L.: Note on a Case of Pancreatic Cyst in a Child Aged Fourteen Months, *Lancet*, 1:803, 1911.

³ Railton, T. C.: A Case of Pancreatic Cyst in an Infant, *British Medical Journal*, 2:1318, 1896.

⁴ Eha, C. E.: A Case of Congenital Pancreatic Cyst, *Journal of the American Medical Association*, 78:1294, (April 29) 1922.

⁵ Thigpen, F. M.: A Pathological Study of Cysts of the Pancreas, (Thesis, University of Minnesota Graduate School) 1940.

⁶ Archibald, E. W., and Kaufman, M.: Surgical Diseases of the Pancreas, *Lewis' Practice of Surgery*, vol. VII, chap. 1, p. 43, W. F. Prior Co., Inc., Hagerstown, Maryland.

⁷ Morgagni, G. B.: *The Seats and Causes of Diseases*, London, A. Millar and T. Codell and Johnson and Payne, 1909, vol. V, p. 578.

⁸ Claessen, H. J.: *Die Krankheiten der Bauchspeicheldrüse*, Köhn, M. Du Mont-Schauberg, 1842, p. 368.

⁹ Le Dentu, M.: Rapport sur l'observation précédente, *Bulletin de Société Anatomie de Paris*, 10:197 (March) 1865.

creatic cyst. He then wrote that cysts of the pancreas should be "relegated to the list of those affections where the healing art is impotent." Bozeman,¹⁰ in 1881, extirpated a pancreatic cyst successfully. Gussenbauer,¹¹ 1882, introduced a method of drainage whereby he sewed the parietal peritoneum to the skin and the walls of the cyst to the peritoneum. This was the beginning of the surgical treatment for pancreatic cysts, known as marsupialization. It is one of the procedures of choice today.

The pancreas is an oblong gland lying transversely across the abdomen at the level of the first and second lumbar vertebrae, the head being in the bend of the duodenum and in contact with it, and the tail extending well beyond the midline to the left and in contact with the spleen. It is about 5 cm. wide at the middle and about 15 cm. long. The gastroduodenal artery lies anteriorly, and the inferior vena cava and the portal vein lie posteriorly. The splenic artery and vein run longitudinally on its posterior surface. The pancreas is entirely retroperitoneal, with the exception that at times the peritoneum may completely cover the tail. It is divided into three main portions: the head; the mid-portion, or neck; and the tail, or caudal pancreas. The main channel which carries the pancreatic secretion extends the full length of the gland and is called the pancreatic duct, or duct of Wirsung. There is a large accessory duct which also drains the head of the pancreas, the duct of Santorini; but this may connect also with the pancreatic duct within the gland. Small ducts penetrate the gland laterally from these ducts. Cysts may develop congenitally in the pancreas as a result of the faulty development of these smaller ducts.

Congenital cysts of the pancreas usually are smaller, and they may be multiple of the acini of the gland. Although parasitic cysts are not common in the United States, the diagnosis is based upon the finding of scolices, or hooklets. They are caused by the *Echinococcus* and the *Cysticercus cellulosae*. *Echinococcus* cysts may be very large, while the *Cysticercus cellulosae* cysts are small. Teratomas are diagnosed by the finding of hair or teeth, or some such substance, in the cyst. Neoplastic cysts may follow malignancy of the pancreas. The most common variety of pancreatic cysts are pseudocysts, so termed because the walls are not lined with epithelium.

It has been experimentally demonstrated that cysts do not form after ligation of the pancreatic duct; but partial obstruction of any or all of the ducts of the pancreas may produce pancreatitis. This fact has been the reason for much speculation in scientific circles. It has been observed that

bile extending into the pancreatic duct will exhibit an extremely marked reaction with possible cyst formation following. Oftentimes pancreatic cysts will form after an attack of pancreatitis. In some instances scar tissue around the ducts has been associated with retention cysts of the pancreas, although a large amount of scar tissue may be found throughout the pancreas without cystic formation resulting.

In the early stages it is relatively difficult to diagnose cysts of the pancreas, although a careful history of the case and the physical findings at examination may suggest the possibility of a pancreatic cyst. If a pancreatic tumor is present, there will be pain in the region of the pancreas in 85 to 95 percent of the cases, the pain usually being due to pressure from the cyst on the surrounding tissues. A history of trauma followed later by pain and swelling may be revealed in approximately 20 percent of the cases. Mahorner and Mattson¹² reported in Körte's¹³ review of one hundred nineteen cases of cysts of the pancreas that twenty-eight of these gave a history of trauma. Judd¹⁴ reported 15.7 percent of traumatic origin, and at the Mayo Clinic it was said that 17 percent out of a total of forty-nine cases of pancreatic cysts were traced to trauma. Most certainly, then, trauma and inflammation of, or around, the pancreas may safely be thought to play an active role in the pathogenesis of cystic development. When blood or hematic products are found in the cystic fluid, it is safe to assume that trauma was an etiological factor.

The differential diagnosis of pancreatic cysts includes: ruptured appendix with diffuse peritonitis; polycystic kidney; retroperitoneal tumors; aneurysms; hydronephrosis; gallbladder disease; and cysts of the mesentery, hepatic duct, spleen, ovaries and the omentum.

Pancreatic cysts may become enormous in size, sometimes containing several quarts of liquid, or they may be quite small. One pancreatic cyst is reported in the literature to have contained twenty liters. The secretion from these cysts is often dark gray in color and may contain some blood or evidence of blood. Pseudocysts are extra-glandular in the fact that the sac does not penetrate the gland. The tumor mass may extend to, and be found in, any part of the abdomen, although the most common site of the swelling is to the left of the midline directly above the umbilicus. The mass does not move with respiration, but if it arises in the tail of the pancreas, it may be freely movable. Malignancy may develop from the pancreas and in the cyst wall itself. All symptoms, naturally, depend upon whether the disturbance is pancreatic

¹⁰ Bozeman, N.: Removal of Cyst of Pancreas Weighing Twenty and One-Half Pounds, *Medical Record*, 21:46 (January 14) 1882.

¹¹ Gussenbauer, Carl: Zur operativen Behandlung der Pankreascysten, *Archives f. Klinik Chirurgie*, 29:355, 1882.

¹² Mahorner, Howard R., and Mattson, Hamlin: The Etiology and Pathology of Cyst of the Pancreas, *Archives of Surgery*, 22:1018-1033 (June) 1937.

¹³ Körte, W.: Die chirurgische Krankheiten und die Verletzungen des Pankreas, *Deutsche Chirurgie*, Stuttgart, Ferdinand Enke, 1898, p. 234.

¹⁴ Judd, E. Starr, Mattson, Hamlin, and Mahorner, Howard R.: Pancreatic Cysts: Report of Forty-Seven Cases, *Archives of Surgery*, 22:838-849 (May) 1931.

only or general. If the cyst is confined to the pancreas there will be symptoms of inanition, weakness, diarrhea, and chronic pancreatitis. If the tumor mass is outside the pancreas there will be swelling of the abdomen with a palpable tumor mass, and symptoms will be exhibited which are due to pressure on other organs of the body. There will be a feeling of tension and fullness.

Tests for lipase and amylase in the blood serum are of but little value in diagnosing pancreatic cysts unless these are made within the first week or ten days following the onset of pancreatitis. Laboratory tests of any kind seem practically valueless in the diagnosis of pancreatic cysts. The roentgenologic observations are very important, since they show the diagnostic contours of the stomach, duodenum, and the transverse colon.

Gallbladder disease may be more easily ruled out of the differential diagnosis for pancreatic cysts if there is no history of biliary disturbance or pain in the upper right quadrant. Nevertheless, we operated recently upon a tumor mass which lay transversely across the upper abdomen directly above the umbilicus, and there was a history of gallstone colic with several years having intervened since the last attack. This tumor was not movable on respiration, and some pain was present. The gallbladder was firmly attached to the anterior abdominal peritoneum, and it contained 1500 cc. of fluid. Also, there was a large stone in the cystic duct.

The treatment of choice for a pancreatic cyst is to resect it completely. Unfortunately this is difficult, if not impossible, in most cases because the cyst may have penetrated deeply into the gland, or the base may have extensively invaded the adjacent tissues. Some surgeons have anastomosed the cyst to the stomach, or to the duodenum, or to the jejunum. The technical difficulties usually are too great, however, to justify this procedure. Although the reports on this procedure show a high percentage of success, in the experience of the average surgeon the most satisfactory method is marsupialization. In our nineteen surgical cases of pancreatic cysts we used marsupialization with no permanent fistulas resulting, and no deaths. In this procedure the cyst wall is attached to the peritoneal wall, and a drainage tube—with or without gauze packing—is placed within the cyst cavity.

REPORT OF CASES

Case 1, Baby D. S.: A boy, weight approximately 30 pounds, white, a twin four years of age, was first seen at the home on the afternoon of October 1, 1939, having been referred to us by the family physician, Dr. Benz. The child was crying with pain in the abdomen. The mother stated that he had not been feeling well for several days, that he had eaten something which had caused the gastric disturbance. There was nausea and vomiting, but no diarrhea. The temperature was 103, and the pulse rate was 120. The abdomen was dis-

tended and rigid, the keenest area of tenderness being over McBurney's point. No masses were felt, and borborygmus was absent. On the right side there was a reducible indirect inguinal hernia. A significant fact of the family history was that I operated upon the child's twin brother for a strangulated inguinal hernia when he was three weeks old, and that he also had a complete perineal hypospadias. A diagnosis of ruptured appendix with diffuse spreading peritonitis was made, and immediate hospitalization was advised.

Laboratory findings were: a trace of albumen in the urine, no sugar or bile present, reaction pH 7.5, specific gravity 1.020, 1 white cell per high power field, no red blood cells; W.B.C. 21,888; polynucleophiles 89 per cent; lymphocytes 11 per cent; hemoglobin 78 per cent, and R.B.C. 4,500,000. The Wassermann test was negative.

On the evening of the same day the patient was operated upon. The abdomen was opened through a right muscle-separating incision after the technique of McBurney. The peritoneal cavity contained blood-tinged fluid. When the appendix was delivered it appeared normal. There was no congestion and no glandular enlargement. It was removed with the usual technique. Exploration of the abdomen revealed a cystic tumor the size of a large grapefruit to the left of the umbilicus and extending about two inches below it. The tumor mass was quite firm and not movable. The source of the cyst could not be determined from this incision. The internal inguinal ring was closed—using the technique of Sudek, the McBurney's incision was closed, and another incision was made above and to the left of the umbilicus. The mass proved to be a multilocular cyst of the tail of the pancreas. This was pressing well downward and posterior to the mesocolon, and it was through this that the cyst was first felt. An incision through the gastrocolic omentum was made, and the cyst was aspirated and opened. The fluid was dark gray in color and contained many clumps of a solid papillary-like tissue. The cyst was attached to and arose from the tail of the pancreas. A large part of the cyst was removed. The remaining part was stitched to the peritoneum. The cavity was packed with gauze, and a rubber drain tube was inserted. The wound was closed with drainage and packing. The laboratory report showed that the culture from the fluid of the cyst remained sterile. There were no pancreatic enzymes demonstrated.

For the first forty-eight hours postoperatively, intravenous injections of glucose and saline were freely given. The temperature rose to 105, the pulse rate to 150, and the respiration to 35. On the third postoperative day the temperature dropped to 99, and the gauze drain was removed. There had been some serosanguinous drainage from the beginning, but the wound healed rapidly, and the patient was discharged to the care of the family physician on October 11, 1939. The rubber drain was removed a few days later. We have seen this boy several times since the operation, and he has remained well.

The pathological report showed that the cyst wall was purple-red in color and cyanotic in appearance. One portion measured 10 by 8 cm. The lining appeared smooth and congested. There was a large mass of organizing fibrin present. Microscopically, the cyst wall presented a flattened epithelial lining. It was thick and densely infiltrated with red cells, polynuclears, and round cells. The diagnosis was: congenital cyst of the pancreas with inflammatory changes and hemorrhage.

Comment: Here is a typical picture of a ruptured appendix with diffuse spreading peritonitis, which proved to be a pancreatic cyst. No tumor mass was felt due to the distension. An interesting feature of this case is the family history regarding the twin.

Case 2, Miss H. V.: A single woman, white, forty-nine years of age, estimated weight 150 pounds, was first seen by us in the home about October 1, 1932. She was hospitalized on October 20 with the following complaints: intermittent attacks of pain in the epigastric and hypochondriac regions for a period of about seven weeks, and difficulty in breathing for about ten days. The patient stated that a few days after the onset of the pain it had spread to the right side below the scapula and to the right shoulder. Her ankles had begun to swell about five days previous to her hospitalization, and the pulse rate had increased. The attacks of pain had become sharp, lasting from a few hours to several days. Prior to her present illness the patient had been comparatively well. "I used to be able to eat what I pleased," she declared; "but now fats disturb me a lot." She had become quite jaundiced about a week following the onset of the attack of pain. The sclera was yellow tinged. The stool was white and clay colored. The breathing was bronchial with distant sounds and a few moist rales. There were moist rales with the end of expiration, which did not disappear with the end of the cough. The chest was dull on percussion, particularly over the right lower portion. The upper right chest was hyperresonant on percussion with breath sounds increased. The heart rate (100) was rapid. The P.M.I. was barely perceptible in the left sixth interspace. There was a systolic murmur, a slight slurring over the aortic area. The left border seemed to be to the left of normal position. The right border was at the edge of the sternum. The abdomen was tender in the epigastrium and below the right costal margin. Neither rigidity nor masses were felt. There was a pitting edema of both legs, and the reflexes were diminished.

The laboratory findings revealed: a trace of bile in the urine, which was otherwise negative, color index .7; W.B.C. 24,350, rising to 37,800 on the second day; polynuclears 76 per cent, rising to 93 per cent on the second day; large lymphocytes 5 per cent, dropping to 3 per cent on the second day; small lymphocytes 19 per cent, dropping to 3 per cent on the second day; large mononuclears 1

per cent; R. B. C. 4,680,000; hemoglobin 55-60 per cent; the van den Bergh test gave a delayed direct reaction. No lipase or amylase tests were done.

There was no history of any previous surgical operations other than a tonsillectomy, and no given history of serious illnesses or of any previous attack of the present illness. The roentgenologic examination showed a pathological process in the right thorax. A working diagnosis of cholangitis and pleurisy with effusion was made. Surgical procedures were not undertaken, and the patient expired from sudden heart failure on the third day of hospitalization.

The autopsy report showed the skin to be yellow-brown in color. There was slight edema of the wrists and marked edema of the legs. The abdominal fat was yellow in color and 4 cm. thick. The intestines were markedly distended, and the gallbladder contained many stones of varying size. There was a stone obstructing the common duct at the ampulla. The liver was enlarged, the right lobe of which extended to the umbilicus. There was marked dilatation of the cecum and collapse of the ileum. The right lung was completely collapsed. The pleural cavity was entirely filled with a gray-yellow gelatinous material. There was a great deal of reaction of the pleura, both parietal and visceral. There appeared to be some shreds of fibrin throughout the jelly-like material. The mediastinum was slightly to the left, but there was not much change in the position. There was a marked enlargement of the lower portion of the mediastinal area on the right side, with an opening directly below the bifurcation of the trachea. From this opening a dark gray material exuded. In the lesser peritoneal cavity a tenacious material was found that extended over the posterior wall of the stomach and along the lower end of the esophagus. A large white plaque was found on the omentum. A degenerative cyst of the pancreas was seen with a sort of pseudopod extending upward through the diaphragmatic opening along the esophagus into the mediastinum, almost to the bifurcation of the trachea. This finger-like cystic tube was a part of the pancreatic cyst, and it was large enough to admit a thumb. It was about 2½ cm. in diameter. At the distal end of it there was a perforation into the right pleural cavity. The abdominal portion of the cyst was large and arose from the tail of the pancreas. The fluid was dark in color. No tests for ferments were run. The left kidney was lobulated. The pelvis was dilated. The calices were degenerated with multiple cysts throughout. The right kidney and the suprarenals appeared normal. The entire intestinal mucosa was hyperemic. The uterus was very large and fibrous. The ovaries were normal. The left fallopian tube was large and cystic, and the lining of the tube was endometrial in character.

The pathological report showed that the glomeruli and vascular apparatus in the kidney appeared albuminously swollen. Many of the convolutions of the glomeruli were vacuolated and

coagulated. The tubules showed very low epithelium and almost complete atrophy of the nuclei. The interstitium was broadened and somewhat coagulated, and it showed a few polynuclear areas. Necrotic areas of the pancreas showed detritus only with no differential cell structure. The islands of Langerhans were atrophied and diminished in number. Broad and thick fibrous bands were seen throughout the sections. There were a few entirely-destroyed areas, which were surrounded by round cellular infiltrations. The intima of the blood vessels of the pancreas was thickened, holding calcium deposits. Very few perivascular round cellular infiltrations were seen in the media and its vasa vasorum. The entire reticulo-endothelial apparatus of the spleen was destroyed, and the pulp cells were replaced by polynuclears. There were many bloody extravasations. The zona glomerulosa of the suprarenals were vacuolated, and the medulla was entirely destroyed. The peripheral parts of the lobuli of the liver were distinct; the nuclei were not stained; the central parts were atrophied. The bile ducts and the peripheral blood vessels were increased in connective tissue and round cells. Bile thrombi were noted. Multiple fibromyomatosis of the uterus was present. The serosa of the pleura and lung was tremendously thickened and covered with fibrinopurulent shreds. The adjacent lung tissue was collapsed and organized. Large thrombi of microorganisms were filling the peribronchial and perivascular blood vessels. Necrosis of the bronchi was noted. Pigmentations of the cells and fibers in the heart were seen, and the blood vessels of this organ were thickened and somewhat degenerated.

Comment: It is to be noted that this case presented the typical symptoms of gallbladder origin, but that pancreatic necrosis was established at autopsy, and that a large pancreatic cyst was found. The lung collapse was due to the fibrinous reaction from the rupture of the cyst which had penetrated extensively into the mediastinum.

SUMMARY

Pancreatic cysts are neither rare nor common, although but one in 8,000 during a five-year period was reported by the Mayo Clinic, and we have seen twenty cases in twenty-five years. Pain is mani-

fested in 85 to 95 per cent of the cases with tumor mass usually directly above the umbilicus to the left of the midline. Etiology varies, trauma being a common cause; also pancreatitis and biliary disease are oftentimes present. Roentgenologic aspects are exceedingly important in diagnosis. Treatment in the hands of the average surgeon preferably is marsupialization. The two cases here reported demonstrate the difficulty of preoperative diagnosis and the unusual locations in which these lesions may occur.

DISCUSSION

DR. A. C. BADDERS (Portland): I should like to ask Dr. Jones about the blood sugar in those cases, as to whether or not it was checked.

DR. JONES: From the reports from the various clinics and the various doctors who have reported, it has been our experience that the blood sugar has been normal in practically all cases.

DR. W. D. INLOW (Shelbyville): In this first case, Doctor, how do you explain this picture of the acute inflammatory condition in the abdomen? I mean with such a fever reaction and high white count.

DR. JONES: I am sure I do not know. I wish I did. There is one outstanding thing in this one case, a thing which particularly hit me in the eye, and it is that you hear people talk about the treatment of ruptured appendix with diffuse, spreading peritonitis, giving statistics on the ruptured appendices cases and making their diagnosis without opening the abdomen. This case to me is an outstanding example—from your blood count, your symptoms, your distension and everything—of a typical picture of a ruptured appendix with diffuse, spreading peritonitis, in which our diagnosis would have been that had we not opened the abdomen.

When we opened the abdomen we found a normal appendix, but a pancreatic cyst was the pathology found. I am sorry I cannot answer the question, because we did not find any reason why the blood count should be up. The x-rays of his chest were perfectly normal. He had a temperature, and I cannot explain why he had it unless it was due to an enteritis or something like that superimposed, but his blood count was 22,000 and his polynucleophiles were 89 per cent.

ABSTRACT: SUCCESSFUL SURGICAL REMOVAL OF SPLEEN OF A PREGNANT WOMAN

The successful surgical removal of the spleen (splenectomy) of a woman eight months pregnant is reported in *The Journal of the American Medical Association* for March 18 by David Polowe, M.D., Paterson, New Jersey. The pregnancy was complicated by a disease of the blood in which there are hemorrhages beneath the skin forming purplish spots (thrombocytopenic purpura hemorrhagica) and which is accompanied by a tumor of the spleen. In the case reported by Dr. Polowe, a large tumor was found

in the spleen. The operation was performed on October 27, and on November 29 the patient was delivered normally of a normal female infant about two weeks prior to estimated term.

As Dr. Polowe points out, thrombocytopenic purpura hemorrhagica is a very serious complication of pregnancy, with fetal mortality rates running as high as 64 per cent and maternal mortality rates almost 100 per cent.

SOME UNUSUAL MANIFESTATIONS OF NASAL ALLERGY*

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All of you are quite familiar with the signs and symptoms of the typical case of nasal allergy. These cases are easily recognized even though they may not always be easily controlled. The thought in this paper is to discuss a few cases of allergy which differed widely in their complaints and objective symptoms from the common mine-run type of case usually seen, and which were entirely atypical in any apparent relationship to an allergic background. However, they proved definitely to be of this type of pathology when studied from the standpoint of allergy.

Among the more common complaints for relief of which the Hoosier rhinologist is consulted are headache, postnasal discharge or catarrh, and nasal blockade with poor breathing. These symptoms may appear singly or in any combination in the same individual. Often these conditions are due to true sinus infection, and from intranasal pressure and obstruction from deviated septa, hypertrophied turbinates, et cetera. Surgical correction and proper local treatment often give the desired relief. Many other cases with the same complaints, however, show little or no sinus involvement or other nasal pathology, and the symptoms go on year after year in spite of various operations and the repetition of different types of local and systemic treatment.

Probably the most common single complaint in the rhinologist's office practice is that of postnasal dripping or catarrh. Early last spring a man consulted me complaining of excessive, almost continuous, thick mucoid postnasal discharge. He also was generally "run-down," felt badly, had poor appetite and frequent attacks of generalized weakness. Antral transillumination was about one plus. Otherwise sinus examination was negative and the nasal passages normal. Antral irrigation returned clear. Under local treatment the postnasal discharge lessened considerably for a time, although the patient continued to feel badly. After a month's treatment, however, the dripping became as bad as ever, and in addition to the posterior discharge the patient began to blow large quantities of mucus from his nose. There had been nothing to indicate an allergic background in this case. Upon suspicion, however, skin tests to various allergens were made. All proved negative except for a slight reaction to a very concentrated mold extract. Treatment with this allergen was administered upon the basis of wishful hoping, mainly, but the patient showed improvement after the fourth injection. The treat-

ment was continued, and at the present time the anterior nasal discharge has disappeared, the posterior dripping has greatly improved, and the patient feels much better, generally. His appetite also has improved, and he has gained ten pounds in weight. This problem of postnasal mucoid discharge is a very common one. All of you, I am sure, have many patients with this complaint. For those stubborn cases which do not respond to the usual measures of treatment, I would suggest the allergic approach. This is not a cure-all, by any means, but quite often, if applied correctly, will bring about results surprising to you and highly gratifying to your patient.

Headaches and head and facial neuralgias are frequent in the rhinologist's practice, and often they are difficult to interpret. Many complaints of this type may be relieved, temporarily at least, by cocainization of the Vidian nerve, of the sphenopalatine ganglion or of the anterior nasal nerve. Surgical correction of intranasal pressure from septal impingement upon the middle turbinate, or simple local shrinkage of these parts, often give the desired relief when specifically indicated. Many other cases of this type, however, receive no benefit from the above measures. In April, 1943, a young woman consulted me, complaining that for the past two months she had suffered severe pain in the upper teeth and antral regions of both sides, accompanied by moderate nasal blocking. Dental examination was negative. The antra were irrigated, but the returned fluid was clear, and no improvement resulted from this procedure nor from other local treatment including cocainization of the various nerves and ganglia. History of family or personal allergic background was entirely negative, but on suspicion, and as a last resort, I tested this patient with house dust. A moderately positive reaction resulted and dust treatment was instituted rather hesitantly and with no great hope for relief of facial neuralgia from this type of treatment. The patient improved, however, and within a short time the nose became clear and the pain disappeared entirely. The pain recurred one evening after the patient had been cleaning an old bedroom rug which she had been advised to discard. This attack lasted for about twenty-four hours and cleared spontaneously. Six and one-half weeks later, on July 21, 1943, the patient returned stating that following the last visit she had been perfectly well for five weeks, but that for the past ten days she had suffered severely again with pain in her teeth and face, accompanied by dizziness, faintness and nausea. This woman lives sixty miles away and was prevented from reporting sooner by the

* Presented before the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association, at Indianapolis, September 29, 1943.

difficulties of present-day transportation. The maintenance dose of house dust was given at this time and the patient later reported that upon the following day the pain and other symptoms were greatly improved and had disappeared entirely within another twenty-four hours. No further trouble has been experienced to date. Apparently this opens up a new field of investigation of causes of neuralgias of the head and face. The role of food sensitization in causing migraine and other allergic headache has long been known. This is the first instance that I personally have known of, however, in which facial neuralgia apparently was caused by allergy, or in which any severe head pain was caused by an allergen of the inhalant group.

Sometimes allergy will superimpose itself upon a true primary infection (or vice versa) and the two conditions will go along hand-in-hand, resulting in additional suffering and distress to the patient and in confusion to the doctor who may readily recognize the one factor and entirely miss the other. Many skilfully performed and otherwise justifiable operations have failed to accomplish the results expected of them and have helped throw modern nasal and sinus surgery into disrepute because a coexisting allergic factor was not recognized nor controlled. The following case is illustrative. This patient consulted me ten years ago, complaining of frequent head colds and persistent postnasal discharge. Bilateral antral irrigation relieved the complaints and no further trouble was experienced for thirteen months, when the patient returned complaining of frequent head colds, cough, sore throat, postnasal discharge and headache—all dating from a recent attack of influenza. Local treatment, antral lavage and antral windows gave only temporary relief, and the patient drifted away, returning seven years later with the same complaints, plus bilateral nasal blocking due to polyps. X-ray at this time (early in 1941) showed much thickening and hyperplasia in the posterior ethmoids and sphenoids of both sides. Bilateral ethmo-sphenoid surgery was performed and the obstructed breathing and other symptoms were much improved for over a year. In June, 1942, an exacerbation of symptoms brought the patient back. She could not breathe comfortably and also complained of much thick nasal discharge, anterior and posterior. Eosinophiles were found in the nasal smear, but skin tests to various allergens were negative. The turbinates were polypoid and obstructive. In addition to the nasal blocking and discharge, the patient had frequent attacks of bronchial coughing and frequent severe headaches. She used nose drops continually, came to the office frequently throughout last fall and winter for such temporary relief as local treatment afforded, and talked of moving to another climate. In May, 1943, I skin-tested her again, and this time I secured marked reactions to histamine and house dust, and smaller indefinite reactions to timothy and ragweed. Treatment with house dust was

started, and within a short time marked general and local improvement was noted. The patient is now breathing freely, the turbinates are much reduced in size and their polypoid degeneration has disappeared. The cough has cleared up, headache is rare, and nose drops and all other local treatment have been discarded. The maintenance dose interval is now six weeks. Just when the allergic factor entered into this case is hard to say. Probably it was several years ago when the polyps and polypoid degeneration appeared, and I will admit my negligence in not investigating the allergic angle when these conditions were first noted, early in 1941, instead of, or at least in addition to, resorting to more surgery at that time. Some time ago Dr. George Shambaugh made the statement that "allergic rhinitis with superimposed sinus infection comprises 70 per cent of all chronic suppurative sinusitis." When first made, this assertion seemed almost unbelievable, but a number of experiences similar to the case just cited have convinced me that Dr. Shambaugh's estimate of the role of allergy in chronic sinusitis is much less radical than it at first appeared to be.

Frequently, puzzling eye conditions also can be solved upon the basis of allergic sensitization. The etiologic relationship of such allergens as pollens, drugs, perfumes, cosmetics, food and bacterial proteins, dusts, molds, et cetera, to conjunctivitis, dermatitis of the lids, iritis, and uveitis has been pointed out by a number of writers. Further discussion of the relation of allergy to the eye has been omitted from this paper with the hope that this phase of the subject will be covered by those present who are more experienced in the field of ophthalmology.

In this paper I have discussed some conditions which we all see frequently—conditions which, when first studied, gave no indication of any allergic background, but which proved definitely to have been caused by allergy, and which responded to allergic management. As mentioned earlier in this discussion, the typical case of nasal allergy is fairly easy to recognize and suggests its own proper treatment. Many conditions which confront us, however, are atypical, offer no indication of any connection with allergy, and will be overlooked unless the investigator is allergy-conscious and willing to dig deeply in this field. All is not beer and skittles in this allergy business. There are many failures and disappointments, but occasionally a difficult case cracks open beautifully and stimulates the worker to further endeavor, even as a two hundred yard drive keeps the golf duffer plugging away.

This paper was written while I was on a recent vacation in northern Wisconsin. It is hoped that its presentation has been entertaining, at least. If it also has been instructive enough to aid in solving any similar problems which may be facing the listeners, the writer will feel amply repaid and will not begrudge the loss of that thirty-pound

muskie which he might have landed during the time spent in preparing this discussion.

DISCUSSION

DR. B. D. RAVDIN, (Evansville): Frankly, I must confess that I have no scientific or formal discussion of Dr. Craft's paper. There are, however, a number of things in this paper that I would like to emphasize.

First, I think that we as rhinologists and ophthalmologists have to recognize one thing: that a great many people who consult us for rhinological and ophthalmological problems have a definite allergic disturbance, either singly or in combination, with some possible pyogenic infection.

If we are to recognize these allergic disturbances in these patients, we have to be in the state of mind described by Dr. Craft. We must be "allergy conscious." I think I have used the term before in reference to glaucoma, being "glaucoma conscious." If you are glaucoma conscious, you are going to find glaucoma. If you are allergy conscious, you will find it in a great many cases because it is there to be found.

Some years ago I became interested in the work of Jarvis. I think he is from Vermont. Jarvis worked with a group that was called a correspondence group. It was made up of outstanding men in this country, and they promulgated the idea that a study of the mucous membrane of the nose showed that the color of the mucous membrane is an index of body metabolism. They advanced this idea and the theory that there are two principal types of mucous membrane. There is a red mucous membrane with various stages of redness, and there is a pale mucous membrane with various degrees of pallor. They called it 1, 2, 3 and 4, if you please, or 1, 2, 3, 4 plus.

Jarvis and his co-workers made the statement that in studying a definite pallor of the mucous membrane of the nose, or degrees of pallor of the mucous membrane of the nose, these patients were definitely of an allergic type or an allergic background. As a rule, they present a subnormal pulse, a subnormal blood pressure, and a subnormal respiration. They will have a subnormal pulse rate. If you go a little bit farther you will find out that a great many of these patients will have a definite minus basal metabolism.

If you go into the laboratory study of these cases, many of them present a very high blood cholesterol and, of course, in the examination of the nasal secretion many of these patients present the typical picture of eosinophilia.

I took the time and the trouble to try to verify this, and I think Jarvis is right in a great many cases. You will find, as Dr. Craft said, that there are a great many nasal problems and nasal conditions in patients in which the signs and symptoms are not definite; they are not clean-cut of allergy, and they are not clean-cut of a pyogenic infection. You may have patients with deformities of the septum; you may even have infections in

the sinuses, but also this same patient may have an allergy and if you are going to think in terms of either one or the other we will continue in bad repute so far as doing intranasal surgery.

I personally feel that since the subject of nasal allergy is here—we know it is here—the quicker we accept it, the better. Then, in a study of all these cases, in the taking of their history and the examination of their noses, let us think of these cases not only as infected sinuses, but let us also think of them as the possibilities of an allergy case and study both phases, and if we look for allergy and for infection we may find one or the other. We may find both, and if both are present they are both going to have to be treated with the end result that the patient is going to be better off.

The subject of allergy with reference to ophthalmology is here, I think. All of us who do eye work I am sure agree with Dr. Craft that perfumes, cosmetics of one kind or another, inhalants, dusts and so forth do produce signs and symptoms referable either sternly or otherwise to allergic symptomatology.

About ten days ago I saw a very interesting case that I would like to briefly review for you. The woman said that she had hay fever for the first time this year. It started about the middle of August. About two weeks after the onset of hay fever she noticed a diminution in vision of the right eye. This gradually grew worse over a period of ten days or more until she realized that she couldn't read newspaper print.

She lives at a distant point from my home, and a friend of hers, who is a patient of mine, came over to see me so she decided to come along. When I examined this woman her vision was 20/100. She had as typical a case of punctate keratitis as I have ever seen. I suggested to her, in view of the fact that it had been present for several weeks, that we ought to try to investigate and find out what was causing it, knowing full well that she had this case of hay fever.

She agreed to come into the city and go into the hospital. She was studied from every possible angle. Every conceivable test was made on her to try to determine the etiology. Nothing was given to this woman in the way of medication. The only thing that had been done to her eye was to dilate her pupil initially for the study of her eye condition, and within three days from the time that she entered the hospital and was discharged the vision in the right eye was 20/30.

I did nothing to her—gave her nothing. I don't know how to account for it. I have never seen it before. The only way that I can explain the case is that it possibly is an allergy—that this case has an allergic background. It is extremely interesting to me. I hope that other men in the audience have had some experience with such or some similar cases and that they may enlighten me.

The thing that I would like to leave with you gentlemen is the fact that, as I said before, we must be allergy-conscious. If we will study all of our cases that come in to us, as Dr. Craft said, that present nasal symptoms of headache, of postnasal discharge, obstruction, difficulty in breathing—if we will look upon these cases and study them from the standpoint of a true sinus pathology and from a standpoint of a possible allergic manifestation or background, I think that a great many of these cases will definitely be picked up.

DR. J. R. FRANK (Valparaiso): There isn't much to add. I have noticed in cases of allergy that when you try to transilluminate them you don't obtain any positive findings. They are practically clear, yet the turbinates are swollen.

We have talked a great deal about allergy of the nose and eye, but the subject of allergy concerning the ear hasn't even been mentioned this afternoon. I just want to call your attention to the fact that allergy also affects the ears, which are directly connected with nose and throat. I have patients come in with that primary complaint, and I find that the trouble in their ears is solely due to allergy, so keep that in mind as a cause of deafness.

DR. CARL B. SPUTH (Indianapolis): I think we are very fortunate in having Dr. Craft bring this important subject before this section. I have been interested in allergy for a great many years, and the more I work with it the more I feel that many of our nasal disturbances—let us include the whole field—the eye, ear, nose and throat disturbances—are due to some allergies.

We have some emotional disturbances which also affect these organs, but hasn't a thing to do with allergy. Most allergy cases are very easy to diagnose. Those of us that have had experience can almost tell by the color of the mucous membranes and the boggiessness of the tissues. They will not respond to adrenalin or ephedrine like some of the congestive types.

It is easy to treat allergy after we know what causes it. It is sometimes very difficult to find out the real cause of these allergies. Those with respect to skin tests and patch tests and so on, of course, are easily diagnosed and treated, but we run into other cases of allergy which aren't so easily diagnosed, and I believe I can best illustrate that by giving the history of a case.

I had a patient who was a train dispatcher, and he works at the Union Station. On examination I found that he did not have much sinus disturbance excepting what you ordinarily get where there is, in addition, the allergy—something there preventing free ventilation to the sinuses. We worked with him for over a year before we could find out the offending cause. We knew he was allergic to dust and other things, mostly to tomatoes and citrus fruits. Every time he went to his office he became allergic.

We thought it was dust, and finally we talked the thing over very carefully and I asked him if he had anything on his desk. Fortunately he said, "Well, the only thing I have on my desk is a linoleum cover."

I said, "Can you arrange to have a new desk or tear the linoleum off?"

He replied, "Why, yes, I will tear it off and put a glass top on it."

From that day on he was greatly relieved when he was in his office. Of course, he had to watch other allergies.

We have contact allergies as well as we have inhalants from foods. They are not very easily diagnosed either. I had a very intelligent young woman come in. She was working in one of our social service departments. She had been to a skin man specializing in allergy. I had been treating her for ear, nose and throat infections and she was constantly breaking out around the lips, the nose and the eyes in particular. It was very discouraging. She had been treated for over a year with no results.

I noticed one day that she had a habit of putting her fingers in her mouth and nose and ears, and rubbing her eyes while she was talking to you. Usually when you have a woman who is allergic, you think that it is face powder or rouge or lipstick or something of that sort. I noticed that she had some nail polish which attracted my attention more than anything else and I asked her how long she had been using that nail polish.

She said, "I have been using that for about a year and a half, possibly."

I asked, "Can you get along without nail polish? I don't know whether it will help or not."

She said, "Why anything to give me relief."

She quit using that nail polish and her allergy cleared up in very short order, so it is not an easy subject.

As Dr. Craft said, you have to be allergy-conscious and be willing to stick with a patient and study him and try this and try that—and keep on trying—and if it is an allergy case I am sure you will have very gratifying results and the patient will be very grateful to you.

I want to drive home another point which Dr. Craft and Dr. Ravdin mentioned. Nasal surgery on a patient with an allergy will not be successful unless the surgery is followed by treatments for his allergy.

DR. CRAFT: This discussion has been more interesting to me than the preparation of the paper. I haven't anything in particular to add except one or two points. The experience of Dr. Ravdin's patient, who entered the hospital and was relieved of her visual difficulty in which he suspected an allergic background, might be explained from two angles: First, from the standpoint of a food sensitization in changing her diet from what she was used to eating at home to the somewhat

different diet that a hospital might prepare for her, or, second, relief from contact with some other type of allergen to which she was exposed in her own home—getting out of contact for several days while she was in the hospital. That might possibly explain it.

It would be interesting to note if the trouble recurred after the patient returned home.

Someone mentioned transillumination in allergy

affecting the antra. It doesn't show. Allergic membranes and polypous growths do not show in transillumination. They do not offer enough obstruction to the light. X-ray will often pick them up when the antra might appear perfectly clear upon transillumination. Emotional upsets and nervous disorders must be taken into consideration in allergy as well as in many other fields of medicine.

INTRADERMAL VACCINE IN THE TREATMENT OF ACUTE BRUCELLOSIS

DAN L. URSCHEL, M.D.*

MENTONE

The use of a heat-killed brucella vaccine in the treatment of acute and chronic brucellosis has been discussed in two previous publications.^{1,2} The preparation used was a stock vaccine containing 1,000 million each *Brucella abortus* and *Brucella suis* per cc. For purposes of skin testing and treatment this has been further diluted so that each cc. contains 166 million each *Brucella abortus* and *Brucella suis*.

In the previous papers no effort was made to describe the results obtained in the acute cases, because most of those reported were of the chronic form. However, four people have been treated for acute brucellosis with this method of therapy up to May, 1943.

Evaluation of results in the treatment of brucellosis is always difficult. It is often a self-limited disease, and for that reason the result of any small series of cases must be regarded skeptically. Many different agents have been advocated for its treatment, usually with somewhat glowing statistical support. Up to this time only two agents have received enough consideration to establish their definite value. Brucellin, prepared by Huddleson, has been used in over two thousand cases in the United States, Mexico, and Malta. Heat-killed vaccine has also been used in many large series, either subcutaneously, intramuscularly, or intravenously. Some workers have prepared extracts, filtrates, et cetera, from the brucella organisms and used them in treatment. In addition to these

specific means, many non-specific medications have been used. The sulfonamides are being used widely, but up to this time no large series has been reported.

There still exists considerable disagreement as to the method of utilization of the existing agents. Huddleson feels that febrile responses are necessary in the use of brucellin.³ Simpson,⁴ Angle,⁵ and many others have used heat-killed vaccine to get sharp febrile responses.

Harris,⁶ in his monograph on brucellosis, says, "The treatment of acute cases with vaccine was abandoned after it was employed in the first few cases. Reactions were severe, and since resistance had already been spontaneously induced by the illness, the principles of vaccine therapy seemed not to apply." Because of similar experiences and dissatisfaction with the "shock" method of treatment, there has been some tendency recently toward the employment of methods which are of aid without the undesirable febrile responses. Castenada⁷ has been treating his cases of the melitensis type with brucella antigens, aiming to produce only mild or no reaction, to desensitize the patient, and at the same time to increase their immune resources.

Criteria for evaluation of therapy are somewhat difficult to establish in this disease. In the patient with acute illness receiving vaccine therapy, which

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¹ Urschel, Dan L.: Brucellosis—a Report of Fifty-three Cases, with an Introductory Report on Intradermal Vaccine Therapy, *J. Ind. State Med. Assoc.*, **36**:294-298, (June) 1943.

² Urschel, Dan L.: Intradermal Vaccine Therapy in Brucellosis, *J. Ind. State Med. Assoc.*, **36**:385-389, 1943.

³ Huddleson, I. F.: *Brucellosis in Man and Animals*, Publisher, Commonwealth Fund, 1943.

⁴ Simpson, Walter M.: Diagnosis and Management of Brucellosis, *Arch. Int. Med.*, **15**:408-430, (Sept.) 1941.

⁵ Angle, Fred E.: The Treatment of Acute and Chronic Brucellosis (Undulant Fever), *J.A.M.A.*, **105**:939, (Sept.) 1935.

⁶ Harris, Harold J.: *Brucellosis (Undulant Fever)*, Publisher, Paul B. Hoeber, Inc., 1941.

⁷ Castenada, M. R., and Cardenas, C. C.: Treatment of Brucellosis with Brucella Antigens, *Amer. J. Trop. Med.*, **21**:185-190, (March) 1941.

TABLE I

NUMBER OF INJECTIONS AND NUMBER OF ORGANISMS NECESSARY TO LOWER TEMPERATURE TO NORMAL

Patient	Age	Duration of illness	No. of injections till temperature normal	Days till temperature normal	No. of organisms needed to bring temperature down
M. B.	12	4 wks.	3	14	83 million
M. K.	22	6 mos.	3	9	67 million
F. R.	69	3 wks.	4	13	1366 million
H. S.	26	6 wks.	3	11	99 million

would mask normal responses in agglutination or opsonic index titres, the disappearance of fever would seem to me the most satisfactory single determinant. For that reason, in reporting these four cases, the drop in body temperature to normal is taken as an indication of subsidence of the acute infection. In all of the cases treatment was continued for some time thereafter, because it was our feeling that relapses might be prevented in this manner.

METHOD

After a preliminary skin test with 0.1 cc. of the diluted vaccine (33 million organisms), the patient was given intradermal injections of vaccine at three- to five-day intervals. The initial dosage was usually .05 cc. of the diluted preparation, although in one of these cases early in our work we used a much larger dosage.

RESULTS

The number of injections necessary to bring the temperature to normal, the time elapsed, and the total number of organisms given each individual in bringing the temperature to normal are all shown on the accompanying chart. These patients were all ambulatory and were given their treatments at the office. None of them had any disagreeable response or apparent increase in fever from the medication, and all got satisfactory results insofar as the acute illness was concerned. One of the cases, F. R., developed a mild psychosis, which cleared slowly. This had developed before he presented himself for therapy and was in no way connected with the treatment used.

COMMENT

The use of intradermal vaccine in the treatment of chronic brucellosis is open to some criticism. Many undesirable responses have been noted by observers who used vaccine in skin-testing sensitive individuals. It has been the writer's belief that most of these reactions could be avoided by proper dosage of the testing agent, and by proper selection of the strain of the organisms used for testing. He has noted no undesirable reactions other than infrequent local necrosis in a large number of injections in many patients. Febrile responses have been very few and the results compare favorably with all other reported series.

The mechanism by which the intradermal vaccine works is not entirely clear. It may be that

in some individuals an allergic sensitization to brucella proteins exists and that their improvement through intradermal vaccine therapy is a desensitization. However, this did not seem to be true in many people. Brucellosis is a disease in which the immune mechanism is often faulty, and it has been the writer's opinion that intradermal vaccine serves to stimulate the normal immune responses within the body. Many authors have reported the appearance of antibodies in the blood-stream after intradermal testing with brucella vaccine or with brucellergen. It was with this in mind that intradermal vaccine was tried. Whether these demonstrable antibodies have a function in immunity has not been proved, but there can be no doubt that they are indicators of some type of host-organism response.

In these four cases the most significant point is the very small number of organisms which was necessary to reduce the fever to normal. As previously stated, in one of them, F. R., a large dosage of organisms was given with the idea that this was necessary to produce the response. In later cases much smaller dosage was used. It would seem that there are many advantages in this method which make it worthy of trial. Because of the absence of sharp spikes of fever, the patient is able to continue his activities if he is not confined to bed by the severity of the disease, and it is a well-known fact that a large percentage of the acute cases of brucellosis remain ambulatory throughout. It is the most economical method of therapy possible because relatively few treatments are needed and the product is inexpensive. It is available to all physicians, and so long as caution is exercised in the dosage, no special precautions are necessary. There are no contraindications to its careful use.

SUMMARY

Four cases of acute brucellosis are reported, which were treated by heat-killed vaccine given intradermally.

Drop in body temperature to normal is taken as the criterion for subsidence of the acute infection. This drop in body temperature was accomplished with very few injections and with a small number of organisms.

There were no disagreeable responses, and the patients were able to remain ambulatory throughout the therapy.



OCULAR PROBLEMS OF WAR WORKERS*

CHARLES H. ADE, M.D.

LAFAYETTE

In the "all out" war effort an increased production of material is being demanded from a decreased number of workers. Maximum efficiency is essential even though the laborers may to a large extent have minimum physical capabilities. Because of the increased demands on the physically fit for active military service, it follows that the physically imperfect must help to a large extent to keep up the fight on the home front.

Three major problems concern both employer and employee in any industrial plant as pertains specifically to ocular problems. First, there is an increased number of employees admitted to the factories who have known errors of refraction and organic eye pathology which may predispose both to lowered efficiency and the increased likelihood of injury. This group includes deficiencies in color and depth perception, stereopsis, and other defects important in specialized types of work. Second, because of the importation of large numbers of workers from every hygienic level of life and because of the close and sometimes careless association between workers there is a definite increase in epidemic conditions including catarrhal and suppurative conjunctivitis, and that most recent and obstreperous stepchild of ophthalmology, epidemic keratoconjunctivitis.

The third major group includes all types of industrial injuries—puncture wounds, contusions, corneal abrasions and burns, both chemical and thermal.

Visual Errors

The first classification includes many conditions obviously not peculiar to war workers but which assume importance when they mean lost time, inefficiency and accidents. A plan of job classification on the basis of visual performance has been devised and elaborated by Dr. Kuhn, of Hammond, and Professor Tiffin, of Purdue. This plan is more reliable than the old Snellen chart and is more accurate on the basis of complete visual performance. Due to the rapid turnover in personnel and the necessity for lowering physical standards in employees, these suggestions and tests are not too frequently used. Consequently, many individuals with eye defects are entering our industrial plants. In the main the classification includes:

1. Jobs where danger is of maximum importance.
2. Jobs where efficiency is paramount.
3. Jobs where neither special safety guards nor special ability is required.

The second group requires those with the best eyesight, while the first group indicates the necessity

for the provision and education in the use of special goggles and other safety devices.

Known refractive errors should, of course, be corrected. In some plants the recommendation is made by the employer or director of the First Aid Department. Usually this is taken care of by the individual himself. Selection of workers on the basis of color sensitivity may in specialized types of work assume importance, just as finding and training of those with extreme acuity or accurate depth perception may on occasion be very important, such as in the selection of crane operators.

The employment of youth of high school age and men and women of retirement age produces peculiar eye problems purely from an age standpoint. These are problems seen more often in wartime than in peacetime. The young worker may need glasses for the first time and the older worker who has not had a refraction for several years may need a change in lenses. In the older worker first signs of cataract or glaucoma may be detected and early treatment instituted. The discovery of all of these conditions as well as the treatment is, of course, of great benefit to the patient.

Infections

The second group includes various types of conjunctivitis as well as epidemic keratoconjunctivitis. In our study a few cases of old trachoma have been discovered. There was also one patient with gonorrheal panophthalmitis. This woman gave a history of having contracted a conjunctivitis while working in a war plant in the southern part of the state. She neglected the original infection which was more or less ignored also by the First Aid station of the plant. She later saw a general practitioner who did not realize the seriousness of the case and treated her but inadequately. Thus several weeks went by before the woman finally saw an ophthalmologist, who obtained a smear and for the first time diagnosed the condition. She was later referred to me and when I first saw her she had an endophthalmitis with an orbital abscess draining from the superior fornix. Enucleation was done because both anatomy and function were completely destroyed. Postsurgical course was uneventful. This case was especially tragic as the woman had been blind in the other eye for several years. I have repeated the history of this case because it is primarily one of neglect which might have had a much happier outcome had the condition been recognized and adequately treated in its incipency. It also serves to emphasize the point that one must never get into the habit of accepting every inflammatory case as one of conjunctivitis without studying the individual case, obtaining smears in questionable

* Presented before the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association, at Indianapolis, September 29, 1943.

cases, and watching for untoward symptoms. An apparently simple conjunctivitis may be the proverbial wolf in sheep's clothing.

Our series includes a number of cases of both catarrhal and suppurative conjunctivitis. These again are not purely occupational diseases, but because of the close association of workers in any given plant they are conditions which may assume epidemic proportions and account for a large number of lost man-hours. Treatment in general may include medicaments such as the local use of eye washes, $\frac{1}{4}$ per cent zinc sulfate drops, topical application of 1 per cent silver nitrate, followed by normal saline or boric acid irrigations. In selected cases we use a 2 per cent solution of neoprontosil locally. Sulfathiazole ointment (ophthalmic) may also be used.

From the standpoint of compensation, cases of conjunctivitis or injuries are a distinct problem because it is very difficult to determine whether the injury or disease is caused by occupation. Usually in our locality the worker gets the benefit of the doubt unless there is definite proof to the contrary.

Corneal ulcers without previous history of trauma or infection constitute a similar problem from the standpoint of lost time and compensation.

While epidemic keratoconjunctivitis probably occurs in endemic form in many parts of the world, especially in the Near East, it has recently attracted much attention by the occurrence in epidemic form in scattered parts of the world as well as in our own country. The disease was first accurately described by Von Stellwag in 1889. In recent times epidemics were reported in Germany in 1940 and at the same time on the other side of the world in Malaya. In 1941 the first epidemics were reported in this country on the West Coast. In San Francisco where the condition was very widespread among workers in shipbuilding companies, the name of shipbuilders' conjunctivitis was given to the disease. It was thought to be caused by something in the welding process.

The cause of this disease is as yet undetermined. There are several theories, perhaps the most plausible being that the disease is caused by a filterable virus similar to that causing herpes. While herpes facialis or labialis has rather often been noted to precede the keratitis or occur with it, the eye lesions differ in several respects. For example, the eye condition is quite often bilateral; there are no vesicles and no ulceration. Many smears on hundreds of cases seem to give no support to the bacterial theory, for there are no constant findings as to type of organisms. Since the disease definitely seems to be communicable, the nutritional and allergic or neuropathic theories would seem to be no more than partly correct. It is quite possible that some of these factors are, however, secondary to the infective agent whatever it may be.

The disease is characterized by an early edema of both the bulbar and palpebral conjunctivae, particularly at the limbus. Early lymphatic involve-

ment of the regional lymph nodes, especially the preauricular, submaxillary, and cervical, is said to be diagnostic. This feature may be very mild, but in the more severe cases may be extensive enough to cause considerable tenderness. The macular infiltrates of the cornea seldom appear before the eighth day and are at first microscopic in size. During the conjunctival phase there is some increased lacrimation but very little or no discharge or suppuration. The hyperemia may be intense, but the pain is often much less severe than the objective symptoms would seem to indicate. The only sensation may be one of a sandy feeling or itching, while in some patients there is an actual hypesthesia. Smears are usually negative or non-specific. During the keratitic phase there is, of course, photophobia and some impairment of vision depending on the number and size of the macules. This stage is quite variable, lasting from a few days to several weeks. Even during convalescence the patient may complain of a halo around lights. Usually vision is practically normal at the end of six weeks. There seems to be no particular correlation between the severity of the symptoms and the duration of the disease, which seems to be self-limited, and the prognosis usually is quite good, there being no residual impairment of vision.

As might be suspected from the non-specific or unknown etiology, the treatment is largely empirical. A combination of therapeutic measures are usually instituted, most of which are palliative. These include cold or iced compresses during the stage of hyperemia and edema, use of eyepads and later dark glasses during the stage of photophobia, and the use of mild local antiseptics. Atropine sulfate 1 per cent, quinine bisulphate 2 per cent, and dionin 3 per cent may be used during convalescence. The latter aids in the removal of the corneal infiltrates. Of the more or less specific therapy, three main types have been used with reputed success. These are roentgen treatments, local use of sulfonamide ointments, and convalescent serum injections. We have used chiefly the sulfonamides and dionin.

Epidemic keratoconjunctivitis, while not a purely industrial disease, has probably accounted for more lost man-hours in war plants than any other one condition and therefore should be considered as a definite ocular problem among war workers.

Injuries

The third group consists of the purely occupational conditions resulting wholly from pure accidents, lack of safety devices, or carelessness on the part of the workers in the use of safety measures. Like all accidents, many are avoidable if proper provision, education, and enforcement of protective measures are utilized to the fullest extent.

About 2 per cent of our total series were cases of puncture wounds resulting from flying fragments of metal or injury from sharp metal points. Some of these flying fragments become embedded and constitute the additional problem of foreign bodies. In

these instances First Aid should be limited to bandaging the eye and referring the patient to an ophthalmologist immediately. The prognosis is always guarded and depends on the location of the injury, secondary infection, length of time after the accident before treatment, and the amount of tissue damage. Small wounds if kept clean may heal with practically no treatment other than antiseptics, while larger ones may need surgical closure. A deeply penetrating wound with loss of vitreous or a badly infected wound usually terminates in enucleation.

Foreign bodies constitute the bulk of industrial eye accidents, comprising 61.5 per cent of our total series, including infections. The majority of foreign bodies seen by the physician are on the cornea, as the more superficial particles on the conjunctiva are usually removed at the First Aid station or by fellow workers. Foreign body cases should be immediately referred to the Health Office or First Aid Station in plants where such facilities are available. Too much emphasis cannot be placed on the education of the personnel of these stations in the First Aid treatment or avoidance of treatment of these cases. Perhaps the most important single piece of advice would be "hands off!" On the other hand, the immediacy of treatment in chemical burns by a First Aid attendant may mean the difference between a good eye and a blind one. As to foreign bodies, an attempt may be made to remove the offending body by irrigations with normal saline or boric solutions, or there may be an attempt at manual removal with a moistened cotton applicator. Certainly this attempt should be gentle, and if unsuccessful should not be repeated at the danger of producing further trauma. Objects on the cornea should probably not be tampered with at all except by an experienced physician. Very slight manipulation may result in corneal denudation with subsequent ulcer formation. Ulcers are more apt to occur in cases neglected for a few hours or days, emphasizing the importance of immediate treatment.

The routine treatment of foreign body cases includes the use of local anesthetic solutions, antiseptics, manual removal of the foreign body and subsequent use of antiseptic solutions or ointments by the patient. Usually the eye is left uncovered. The chief complication of foreign bodies is, of course, corneal ulceration, and it must be borne in mind that this may result from over-zealous treatment as well as from the initial injury. Ulcers recognized early are usually successfully treated by silver nitrate or trichloroacetic acid cauterization.

Penetrating foreign bodies constitute a much more serious problem and offer a much worse prognosis. First Aid treatment should consist only in bandaging the eye and sending the patient to the hospital where the ophthalmologist attempts to remove the object under strict aseptic precautions. Foreign bodies in the anterior chamber may usually be located and removed. In the posterior chamber the roentgen ray often helps in locating the foreign

body if it is radiopaque. In any questionable case x-ray should always be utilized before any surgery is done. The electromagnet may be tried in the removal of magneto-sensitive objects after they have been definitely localized. If the object cannot be localized, we feel that it is better to be conservative and watch for symptoms of infection rather than do too hasty surgery as a certain number of those patients with embedded objects suffer no permanent damage nor impairment of vision. The majority, of course, will develop an endophthalmitis and enucleation will have to be done. Other complications of foreign bodies in general include retinal damage, corneal opacities, uveitis, traumatic cataracts, and intra-ocular hemorrhages. The prognosis of foreign bodies, especially the deeper ones, should be guarded for several weeks as latent infection or impairment of vision may occur. These constitute compensation as well as medical problems.

Contusions resulting from a blow against the eyeball comprise about 9 per cent in our series of cases. These result from explosions, falling objects, or a direct blow caused by the individual running into something. The majority of these recover spontaneously in ten to thirty days with only palliative treatment. In very severe contusions loss of the eye may result.

Most of the burns treated in our office are the result of chemicals. In our vicinity the majority of such cases have alkaline or caustic burns although a certain number are, of course, from acids. First Aid treatment in chemical burns is of utmost importance. There is no other eye condition in which prompt attention is so important. This is an emergency of the first class, and adequate First Aid might save the eyesight of many a man. The chief problem is therefore one of adequate training of First Aid personnel in the immediate treatment of the types of burns most likely to occur in any given plant. It is well for fellow workers to know at least enough to use immediate irrigation, especially in plants where there is no nurse nor physician in attendance at the plant.

The most essential and most urgent treatment is that of copious irrigation. Normal saline or sterile distilled water should always be available in large quantities. In acid burns the damage to the eye is almost instantaneous but is not progressive. One generous irrigation may therefore be all that is necessary. The sooner it is done, the better the results are. After irrigation the patient should be sent to a physician who should stain with fluorescein to determine the extent and depth of the injury to the cornea. Local anesthetics, preferably pontocaine or butyn, should be used. Cocaine should be avoided because of its tendency to dry the membranes. Antiseptic ointments should then be generously applied, both for the antiseptic properties and in order to prevent adherence of denuded membranes. Atropine sulfate as a prophylactic against iritis is usually recommended, as well as the use

TABLE I
ACCIDENT REPORTS FROM MAY, 1942, UP TO AND INCLUDING JULY, 1943
Frequency in Number of Cases per Million Man-hours of Work

Month	Foreign	Frequency	Caustic	Frequency	Spirits	Frequency
May	5	5.	2	2.4	....	.....
June	3	3.25	1	1.12	....	.....
July	6	6.70	3	3.33	....	.....
August	7	7.42	1	1.06	....	.....
September	3	3.21	1	2.14	....	.....
October	3	3.06	1	1.02	....	.....
November	7	7.35	....	.....	....	.....
December	3	3.02	1	1.008	....	.....
January	3	2.94	1	.98	....	.....
February	2	2.14	....	.....	....	.....
March	2	1.98	....	.....	....	.....
April	1	1.02	2	2.04	1	1.02
May	3	2.73	1	.91	1	.91
June	1	.84	....	.....	....	.....
July	3	2.6	....	.....	....	.....
TOTAL	52		14		2	

of eyepads and dark glasses until healing is well on its way.

Alkaline burns differ from acid burns in that the damage is progressive and continues even after the causative agent is removed. The treatment differs only in longer and repeated irrigations. These should be repeated or continued for as long as an hour. If the chemical source is not known, it is always safer to treat as an alkaline or caustic burn. Testing the conjunctival secretion with litmus paper may help in the diagnosis. Constant watch should be maintained for symblepharon and ulceration. If adhesions tend to occur, they should be kept broken down by gentle manipulation with a glass rod. Treatment is essentially the same as for acid burns except for the more vigorous irrigation. A large majority of the cases that we see are the result of caustic burns from sodium hydroxide used in the processing of aluminum tubing.

Flash burns result usually from the momentary exposure of the eye to the flash from a welder's arc. These burns are especially painful. Stronger anesthetic solutions are therefore indicated in the treatment of these burns. The anesthetic may need to be continued for several days. A heavy oily substance, such as castor oil, may be used to prevent adherence of inflamed and dry surfaces, although this is of more importance in actual burns. This in itself offers considerable relief. Recovery is usually complete in four to ten days.

In all burn cases consideration should be given to the early and subsequent treatment of surrounding facial structures, which are almost always burned if the eye is injured. This includes anti-septic and soothing medicaments early with possible plastic repair later.

In the case reports from the Aluminum Company of America, (Table I) which is the largest war plant in our locality, some rather interesting conclusions may be noted. In the last fifteen months—up through July, 1943—an average of 3.5 per cent of foreign body cases occurred per one million man-

hours of work, and less than one case of chemical burnes per million man-hours of work. Other miscellaneous cases from a percentage standpoint were almost negligible. The largest number of cases of each type of injury occurred during July and August of 1942. In November of 1942 there was also a large number of foreign-body cases but no burn cases. Perhaps the most interesting feature is the very definite drop in all types of accidents in the more recent months since physical and other requirements have been markedly lowered. This can only be explained by the increased education of employees as to hazards, the more vigorous enforcement of available safety precautions, such as wearing goggles, and the fact that lost time due to carelessness or failure to use precautions is not paid for by the company. If a case can be proved due to negligence, the employee does not get sickness insurance.

To recapitulate, the ocular problems of war workers may be classified in three groups, those which are errors of refraction or visual inadequacy which antedate employment but which become problems after employment, those of infective origin which are important from an epidemic standpoint and which mean a great deal of lost time, and those which are definitely occupational conditions due to injury. The latter consist chiefly of foreign body cases and those of chemical burns. The problems from the physician's standpoint consist chiefly of remedial and therapeutic procedures, as well as the training of First Aid personnel. Industrial physicians usually are general practitioners, and these should have enough specialized training to recognize and differentiate the potentially serious conditions and know which ones need the care of an ophthalmologist. This is of importance not only from the patient's viewpoint but also from that of protection to the employer or company. Where there is no physician in constant attendance, the nurse or First Aid worker should have very definite criteria as to the prompt and adequate treatment of emergency cases, such as burns, also very definite

knowledge as to what not to do in the case of foreign bodies on the cornea, for instance. The real problems then are those of First Aid treatment,

and of these the knowledge of what not to do is of as great importance as what to do and how quickly to do it.

BOTULISM MAY OCCUR AGAIN IN INDIANA

J. W. JACKSON, M.D.*

INDIANAPOLIS

Botulism is a rare disease in Indiana. Only three outbreaks have been recorded in this state: one in Decatur in 1919, 7 cases and 5 deaths; one in Mishawaka in 1921, 2 cases and 2 deaths; and one in Fort Wayne in 1922, 9 cases and 4 deaths. As revealed in Table I, the mean number of cases for the three outbreaks was 6, the mean number of deaths 3.666, and the mean case death rate percentage was 71.96.

TABLE I
RECORDED OUTBREAKS OF BOTULISM IN INDIANA

Year of Occurrence	Place	Number of Cases	Number of Deaths	Case Death Rate Per 100 Cases
1919.....	Decatur	7	5	71.43
1921.....	Mishawaka	2	2	100.00
1922.....	Ft. Wayne	9	4	44.44
	Totals	18	11	215.87
	Means	6	3.666	71.96

It is interesting and may be significant that all these outbreaks were closely associated as to time with World War I. Those who are entrusted with the preservation of community health on the home front should make every effort to prevent medical history from repeating itself as military history has done. Botulism always follows the ingestion of improperly canned, smoked, or packed foods that have been stored for a time. Fresh foods never cause botulism. Untold thousands who are not skilled in home economics will, nevertheless, process food during this national emergency. Hence, doctors and health officers should be alert to meet emergencies that may come from poisoning due to the improper canning of foods in the home.

Ineffective methods of canning still used in many homes include the so-called "cold-pack" methods, "oven-processing" and "hot water" techniques. These methods may not destroy all pathogens, especially those that are resistant to heat; for example, *Clostridium botulinum*. Pressure-cooking appears to be the most effective method that has as yet been advocated for the preservation of perishable foods. It is especially recommended for nonacid foods. However, botulinum may occasionally develop in acid foods. Furthermore, it may survive in a pressure cooker if the apparatus is not properly used.¹

Clostridium botulinum, a comparatively large, stout, motile, rod-like plant, is known to have five types: A, B, C, D, and E. The germ is a normal inhabitant of the soil of many countries, including the United States. Although its distribution is probably universal, it appears to be especially abundant in the soil of California, Washington, Oregon, Montana and Colorado. The germ itself is not killed by low temperatures or by quick freezing. The spores are also remarkably resistant to heat. In one experiment they withstood boiling for 5½ hours; in another they were not killed by exposure to a temperature of 240 degrees F. for fifteen minutes. The spores may lie dormant for long periods, 144 days or more, and then produce strong toxins. In another experiment the spores were still viable at the end of six years. On the other hand, another authority asserts that although spores may survive boiling for at least three hours, they are always destroyed by steam at 15 pounds for 15 minutes. This apparently contradictory conclusion could have been due to the use of an autoclave without separate thermometer and gauge, to difference in the ability of strains of the organism to resist heat, or to other variables.

The bacillus grows in the absence of oxygen, in decaying animal or vegetable matter, or in the sealed can of an improperly processed nonacid food; for example, a can of beans. During its growth it produces the most powerful toxin we know. It is alleged that deaths have resulted from merely touching a piece of string bean to the tongue after which the mouth was as thoroughly cleansed as possible. Neither the germ nor the spore is poisonous. The organism does not grow in the human body, and usually not in an acid medium. All humans have probably swallowed these organisms from time to time and never noticed any ill effect, but few who ingest the poison live to tell the story of that experience. Fortunately, the toxin is easily destroyed by heat; hence, the alert housewife boils all processed foods or leftovers that have been opened and stood for forty-eight hours or more. This procedure destroys the toxin *providing every part of the food is heated to the boiling temperature.*

The ingestion of food containing botulin induces symptoms of illness, a form of food poisoning. Most lower animals are also susceptible, especially horses, cows, chickens and ducks. Many outbreaks

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¹Prophylaxis is more fully discussed in the *Monthly Bulletin*, Indiana State Board of Health, 47:172, August, 1943.

have occurred resulting in the death of domestic animals. In some cases an entire flock of chickens died, usually following the consumption of canned food discarded because of spoilage. In humans the illness is called "botulism." The term was derived from the Latin words "botulus," a sausage. In Europe many outbreaks of botulism were caused by contaminated meat, especially sausage; hence, the name "botulus" was applied by a German physician early in the nineteenth century.

Botulism is comparatively rare. It is not a communicable disease; it is an intoxication. In man the symptoms are characteristic. The incubation period is not well defined, but is usually from 12 to 108 hours. The patient may have no symptoms at all until 12 to 36 hours after ingestion of the peccant food. He then suddenly finds that he has hyposecretion or hypersecretion of a thick, viscid saliva, external or internal ophthalmoplegia, dysphagia, aphonia, constipation, retention of urine, diplopia, mydriasis, ptosis from paralysis of the third nerve, and perhaps some abdominal discomfort or vomiting. Other symptoms include extreme muscular weakness, paralysis of the pharyngeal muscles, inability to swallow, and obstinate constipation. Still later, air hunger, followed by complete paralysis of the respiratory muscles, may be the immediate cause of death. The temperature is usually subnormal. Strangely, the patient may be mentally clear until the end. The duration of illness is usually 3 to 6 days. Brouchopneumonia or aspiration pneumonia may develop as a complication of the intoxication. Death may occur within 24 hours or be delayed for a week. Survivors may not fully recover for many months.

How great is the menace in individual outbreaks of botulism? What is the average number of patients per outbreak? How many of the patients may be expected to die? What is the mean death rate? In an effort to answer these questions pertinent data of individual outbreaks as reported in the literature by various investigators were tabulated. Not all the available data were used. Clinical as well as laboratory findings were accepted as criteria of the validity of the diagnosis of the outbreaks of botulism.

Of the 187 outbreaks, 101 were diagnosed on the basis of clinical evidence and 86 were confirmed by laboratory proof. This study included many of the outbreaks occurring from 1899 to 1902, inclusive. A total of 709 patients was tabulated. The number of cases per outbreak ranged from 1 to 29. The mean was 3.7914, 3.7915 (standard deviation). A total of 437 deaths occurred. The mean number of deaths per outbreak was 2.3368, 2.255 (standard deviation).

The range of the individual case death rates of the 187 outbreaks varied from zero to 100 per cent. The mean was 68.1487. The standard deviation is 34.65, and this is 50.8 per cent of the mean. The

case death rate was 100 per cent in 82 (43.85%) of the outbreaks.

Meyers, using more complete data, tabulates 359 outbreaks with a total of 1,024 cases and 669 deaths. These data indicate an average of 2.853 patients per outbreak, and a case death rate of 65.33.

When a case of botulism occurs, other members of the household should call the family doctor immediately. If botulism is suspected the doctor should attempt to establish proof of his assumption and seek the vehicle of spread, the reservoir from which the organism came, and the specific meal and food substance responsible for the poisoning. To ascertain the vehicle of spread, the foods ingested must be listed. Each person should be interviewed individually. The doctor then summarizes this information and prepares a complete, alphabetical list of the foods eaten at the peccant meal. The doctor may then inquire as to illness in those who ate leftovers. If any of the leftovers were thrown to chickens the fate of the fowls should be ascertained. Did any of the fowls die? Were symptoms of limberneck observed?

The doctor may usually safely eliminate the human carrier as the reservoir in an outbreak of botulism. He may safely concentrate on the identification of a food responsible for the outbreak. Careful search should be made for remnants of the suspected food. These should be sent immediately to the laboratory. Immediate investigation should also be made of the methods of the maker of the product. Some flaw in his technique of preparation or preservation may have resulted in contamination. Materials that may be sent to the laboratory include suspected food, specimens of vomit or feces, and specimens of the bowel obtained at autopsy. The presence of toxin in the sample is determined by the injection of portions of the extract of the suspected sample into mice. Cultures may be suggested.

Should the doctor conclude that the illness is botulism, he should immediately report the case to the Indiana State Board of Health, as required by regulation. This procedure could be helpful to both physician and patient, for this organization has arranged with the agents of a manufacturer of biologicals to keep a small supply of botulinus antitoxin available at all times. Antitoxin is of no value after symptoms have appeared; nevertheless, since antitoxin is the only known specific remedial agent, its use is advocated by some even in far-advanced cases.

Botulinus antitoxin is the whole blood serum of horses or other animals that have been immunized by continued and progressively-increasing doses of botulinus toxin. The antitoxin contains antibodies against toxin of Types A and B. *Clostridium botulinum*. Antitoxic serum of each type is produced in separate animals. The serum of the immunized animals is mixed in proper proportions and then tested for potency and sterility.

In case of an outbreak of botulism, all individuals known or suspected to have eaten any of the poisoned food should be given a preventive dose of botulinus antitoxin, Types A and B combined, at the earliest possible moment. For prophylaxis, from 2,500 to 5,000 units should be administered subcutaneously. For treatment, inject 10,000 units or more intravenously and repeat in twenty hours if necessary. Intradermal sensitivity tests are necessary. Other phases of treatment may include emptying the lower bowel by means of a soapsuds enema (2 ounces of soap in a pint of warm water). High enemas of soapsuds and olive oil may then be given with the object of neutralizing the toxin. In patients who are seen early the stomach may be washed. Gastric lavage may be very useful in patients seen before the onset of paralysis. Some authorities recommend this be done with a solution of sodium bicarbonate and that after the procedure

has been completed two ounces of castor oil may be introduced before removing the tube used for lavage. Some have considered it helpful, especially if pharyngeal paralysis is developing, to introduce a duodenal tube. When left in position, fluids, including 10 per cent glucose, fruit juices and water may be administered. If this device is not immediately available, or after paralysis of the pharyngeal muscles, fluids may be administered parenterally. Removal of mucus by suction may help prevent aspiration of this secretion. If the paralysis includes the respiratory mechanism, a respirator may be necessary. In some instances catheterization is required. Restlessness and undue apprehension may be alleviated by absolute bed rest and by the use of potent sedatives. Attendants usually should not move or bathe the patient.

ABSTRACT

DESCRIBES METHOD WHICH MAY COMBAT THE SHOCK FROM BURNS

A possible means of combating the frequently fatal shock that accompanies severe, extensive, third degree burns is described in *The Journal of the American Medical Association* for January 22 by Charles L. Fox, Jr., M.D., New York, in a preliminary report on the administration by mouth of sodium lactate solution instead of administering plasma by injection into a vein. (Sodium lactate is an organic salt found in sour milk, certain other substances and in the arterial blood plasma.)

"The results were so successful as to warrant further extensive trial of this therapy," he says. "There was but one death (which occurred within four hours after admission) in seventeen cases of full thickness [third degree] burns."

As Dr. Fox points out, "The shock syndrome which follows severe burns is accompanied by hemoconcentration and diminished plasma volume." Recently plasma transfusions have been used as a means of restoring the diminished plasma volume.

"Recent accounts of two catastrophes involving many burn cases, the Japanese attack at Pearl Harbor and the Coconut Grove fire in Boston," Dr. Fox says, "have indicated the relatively high mortality from severe burns even when large amounts of plasma are used."

He points out that recent investigations have revealed that when large plasma transfusions were administered soon after the receipt of the burn, there was not as great a rise in the plasma volume as had been anticipated, and, as a rule, the rise that was obtained proved to be only temporary. As far back as 1926, Dr. Fox says, the late Dr. E. C. Davidson advised the administration of sodium chloride in severe burns instead of dextrose solutions, because Davidson had observed that the plasma chlorides of patients suffering skin burns were low and the urine almost devoid of sodium chloride for as long as three weeks after the burn, in spite of adequate salt intake.

The procedure reported by Dr. Fox involved the immediate administration by mouth of large amounts of a chilled sodium lactate solution and at fifteen minute intervals thereafter on schedule. Any vomiting, which frequently occurs in severe burns, was treated by the administration of more fluid, and frequently a small tube was passed through the nose and connected with a drip apparatus so that the sodium lactate was administered constantly. A very careful record of fluid intake is necessary and the urinary output has to be carefully watched and all urine collected.

All cases of heat burns admitted to Harlem Hospital since Feb. 1, 1943, and one case of severe burns admitted to the Babies Hospital have been treated according to this procedure. The local treatment of the burns involved the application of an ointment containing tannic acid and either sulfadiazine or sulfathiazole.

"In general," Dr. Fox says, "the large volumes of fluid were well tolerated; the patients wanted water to drink but after a short time became accustomed to the lactate and drank copiously of their own volition. Occasionally, frequent vomiting occurred and was treated by passing a Levine tube and administering the lactate by steady drip. When the initial vomiting persisted, intravenous infusion was used temporarily to support the circulation until the stomach became adjusted to receiving the steady flow of sodium lactate. . . ."

"As these cases require from one to eight skin grafting operations, the extent of full thickness burn could be definitely ascertained. The results in these severe burns constitute prima facie evidence of the therapeutic efficacy of large amounts of oral sodium lactate instead of intravenous plasma. . . ."

Dr. Fox says that the observations by Davidson on the disappearance of the chlorides from the urine were strikingly confirmed in the series of cases he reports. Further studies of the redistribution of sodium by the body are in progress, and an extension of the studies he and his colleagues have already inaugurated may answer, he says, the important question as to whether a judicious combination of small amounts of plasma with sodium lactate might be more effective than sodium lactate alone.

"Whatever may be the ultimate conclusion about the added benefit of small amounts of plasma," Dr. Fox continues, "the fact that extensively and severely burned patients survived and recovered after the oral administration of isotonic sodium lactate instead of the intravenous injection of plasma, proves that correction of the sodium imbalance is of major importance. . . ."

"The simplification in the care of such patients is worth noting. Intravenous therapy is dispensed with and the medical staff and nurses are relieved of this burden. The sodium lactate costs but a few cents and the hospital supplies of blood and plasma are conserved. The problems of sterile solutions are eliminated. He admonishes, however, that final judgment on this method should await more complete reports.

THE JOURNAL OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

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APRIL, 1944

Editorials

SECOND INDUSTRIAL HEALTH CON- FERENCE OF THE INDIANA STATE MEDICAL ASSOCIATION

Last year our Medical Association was asked by the Procurement and Assignment Service to develop a plan whereby physicians could be trained for positions in war industries. The Indiana Plan was developed and, after its trial in the state, was adopted by the Advisory Committee on Industrial Health of the Procurement and Assignment Service as a model for other states to follow. At that time the general consensus of opinion was that "It couldn't be done," but Dr. E. S. Jones, of Hammond, and his Committee on Industrial Health *did it*.

This year we have a still greater problem to help solve. In addition to training physicians for war industries, we have the immense problem of rehabilitation and placement of the physically-handicapped veteran in industry. Unless we, as physicians, can recommend placement of the handicapped veteran on the job that he can perform with safety to himself and others, our entire rehabilitation program will fall down miserably. No amount of good plastic surgery, training, and development of new skills will land the veteran a job unless the plant physician knows how to use this handicapped veteran in the plant.

In our opinion the success of the program will depend upon the attitude of the physician toward the use of such a labor force in his plant. In order to help Indiana physicians understand this phase of medicine, and to help them evaluate their own problems, the Second Industrial Health Conference of the Indiana State Medical Association will be devoted to medical problems in placing a handicapped veteran.

In order to accomplish this task, nationally-known speakers have been invited to develop this program. The session is designed to be practical, and definite workable plans for the employment of the handicapped veteran will be presented.

Last year the Committee on Industrial Health did a big job, but this year they really did the "impossible." In this busy war-torn world they were able to secure experts from all over the country to participate in this conference. Each speaker is an authority in his own field, and getting such men for a committee-sponsored state meeting is certainly an achievement. Achievement? Yes, in a way. Probably the real answer lies in the fact that these men know that rehabilitation and placement of the veteran is the biggest problem we have to face, and that if it is going to be licked it will have to be done on a *local level* where *each physician and each plant* will do their best to use this type of personnel. Thus, these men, busy as they are, know that they must find time to participate in such meetings else the entire scheme may fall through.

Let's back our boys by letting them know that, come what may, *Indiana Medicine is thinking about them and is planning for their return to a job, a home, and economic security*. That is the least that we, who have been left behind, can do. The boys will be glad to know that the doctors back home are thinking in terms of rehabilitation and employment of the handicapped. Will that help morale and get this war over sooner? What's your guess? We'll see you in Indianapolis, April 19 and 20.

THE CANCER PROBLEM IN 1944

It is perhaps needless to say that cancer is still with us. In the year 1943 there were 4,406 deaths in Indiana, which gives a cancer death rate of 128.1 per hundred thousand population. This figure is approximately the same as the corresponding figure for 1940, 1941, and 1942, but is higher than in years previous.

Obviously, the picture is not too bright, but we must recall that this is a very insidious disease that goes right down to the very roots of the source of life itself inasmuch as it is fundamentally a disease of the cells which are, of course, the units of our body structure. Consequently, it is not reasonable to expect a quick victory against this group of diseases.

The month of April has been set aside for publicity on the subject of cancer and is a time for

raising money to support research to fight this enemy to human life and progress. The last year has presented no outstanding research discovery which offers us new hope, but as we come to appreciate better the resources of science that are in our hands, the picture is not as dark, by a great deal, as it might be.

In the first place we are now beginning to understand the causes of cancer. Cancer is simply an abnormal growth of the cellular tissue of the body. We do not know all of the causes that bring it into existence, but we can say without any question whatever that cancer is *not infectious*. We can say that while chronic irritation of susceptible tissues is not the only cause of cancer, certainly many cases of cancer are due to chronic irritation of particularly susceptible tissues. The tissues that are more susceptible than others are those that lie in places in the body where one tissue is adjacent to the line of transition with another tissue as, for example, the lip margin where skin is immediately in contact with mucous membrane.

We know that the cells of some persons' bodies are more likely to "go off on a tangent" of this sort than are the cells of the bodies of other persons. In other words, heredity does have something to do with this, there being some persons whose cells are much more subject to cancerous change. Members of such families certainly are not doomed, by any means, but they should be more careful in watching for first signs of malignant growth.

Very definitely there are only three methods by which cancer may be treated with good reason for real success, namely, surgery, x-ray and radium in the hands of competent specialists using up-to-date equipment. We are in a position to insist that every piece of tissue suspected of being cancerous should be subjected to microscopic examination, and that a careful record be made of the findings and also that the sections be preserved.

Education, both of the public and of the profession, in early diagnosis so that cancer may be recognized and treated at the earliest possible moment is of utmost importance. Furthermore, it is extremely important that follow-up be carried out as long as possible, to the end that metastases may be recognized early and treated at once with x-ray or other appropriate means.

Research on cancer causation and treatment should continue. Ultimate success may be expected of such endeavor carried out over years of time. The money raised by The Women's Field Army, by private subscription, and by public appropriation is absolutely essential to final success of this program.

In other words, the cancer situation, bad as it is, is by no means hopeless. Great progress has been made during the past several years, and will probably be continued. It means that the whole effort against cancer must be carried out as a

coordinated whole rather than as sporadic attempts here and there. This is one of the biggest problems before the populace and the medical profession.

SOME CHANGES AT HEADQUARTERS

In a recent number of *THE JOURNAL* we commented on the fact that the Indiana State Medical Association, as well as *THE JOURNAL*, had had "growing pains" for many months, and suggested that the powers that be, in this case principally the Executive Committee, make a survey of the situation and, if possible, do something about it. Just how much weight our editorial carried we do not know, but it is true that things have been done, much to the satisfaction of all concerned.

For years past there has been a crying need for additional space and additional help. Now we have both. The headquarters' staff will be added to, and *THE JOURNAL* has what it long has needed—a little of suite of rooms all its own.

As we have said, things had come to such a pass that when *THE JOURNAL* had visitors we were much embarrassed over the fact that there hardly was a place for a visitor to sit down. Our little office resembled nothing less than the editorial sanctum of an old-time weekly country newspaper where the editor had one small flat-top desk and a chair, the desk serving as a storage space for accumulations of many years.

The same might be said of headquarters, too; they were cramped for space to the extent that what long ago had been planned for a library became a repository for the overflow which every active state organization must have. Almost any day the large table therein, which was supposed to be set apart for the conferences of the mighty, would be found overlaid with material which was in the process of being made ready for the mail. And when extra help had to be called in, which happens rather frequently, a place would have to be found for that extra person to work—no small job.

Now things have changed; *THE JOURNAL* has moved a short distance down the hall, Room 1017—a rather small suite but one that fits the purposes very nicely—and when *THE JOURNAL* has to call in extra help, which also happens occasionally, we now have a place in which this person can work. Then, too, we finally have a small library, which will be used for just that. Our filing cases are once more get-at-able; we know where to lay our hands on cuts and such things as our printer is demanding; we have more than a semblance of order—we have order about the place, and all this means a better magazine, since the time-saving is of no small moment now that we have a real home.

Our library, though small—it was started less than a dozen years ago—covers a wide range in the field of medicine. We also have the bound volumes of *THE JOURNAL* for the past thirty-six years, plus a copy of all the bound transactions of the Indiana State Medical Association. (You may recall that prior to the founding of *THE JOURNAL* the full report of our annual meetings was published in book form.)

We also have many other items of historical value in medicine, and, best of all, the library is immediately available. No longer is it necessary to ask someone if we have “so and so”; if we have it, it is right there in front of you, together with a cozy place to sit down and read to your heart’s content. Already, one Indianapolis physician, viewing the new setup, remarked, “My goodness, I did not know that *we* had a library; here I have been calling the Medical Department of the Indianapolis Public Library whenever I wanted to see a medical book; now, I’ll just come up here.”

The space formerly occupied by *THE JOURNAL* fills the present needs of the headquarters’ staff; they now have sufficient room to carry on to much better advantage. All headquarters’ folk are mighty pleased with the change, especially secretary Tom. He, of course, wanted to throw a party, have open house and a general celebration, but that was vetoed; everyone connected with headquarters is too darn busy for parties. So, just drop in and see us; look around and we are sure you will agree that we have made a move which will be of material benefit to the Association and to *THE JOURNAL*.

KITCHEN-MADE PENICILLIN

For the past year or so we have heard fabulous stories about the healing properties of penicillin. As a matter of fact, the stories have been so big that at times it has seemed almost impossible that they could be true, yet experience seems to confirm them, and those who are in the know on that sort of thing assure us that even greater things may be expected in the future. Such being the case, we might expect that there would be bootleg development of the product, especially in view of the fact that the regularly-produced drug is to be allotted entirely to the armed forces, except for very small amounts which are being used for experimental purposes and also for cases of unusual importance in the civilian population.

Whenever a product comes out with great promise and the supply is strictly limited, it is only natural to expect that efforts will be made to get the benefits of the drug by some means or another, which are certainly not orthodox and may be dangerous.

It will be recalled that in the early days of sulfanilamide therapy there was a very serious accident due to the fact that a company wishing to put the product up in liquid form used a solvent that was highly toxic and caused more than a hundred deaths. It is not surprising at all that there should be efforts made in doctors’ offices, in the backrooms of drug stores, and even in people’s homes to produce this potent remedy. To be sure, they can hardly expect to refine the drug as it is being purified in the large laboratories which are specially equipped. Likewise, it is certain that most of these people trying to grow penicillin will not be in a position to prevent contamination. Certainly none of them will be able to assay the product. They simply grow some kind of a mold, which is frequently not the kind of mold that is used by the pharmaceutical houses but is simply in many instances a bread mold, and then when they get the growth they apply this growth in some manner to the wound. The manner in which this product is made in kitchens and in the backrooms of drug stores should teach us that it is utterly unreliable from the standpoint of strength, and that it might very easily be contaminated with other organisms, some of which could be very dangerous. Rarely indeed will these people have any assurance whatever that the product has any curative value, but they are simply using it in the hope that such may be the case.

It is obvious to every scientifically-trained physician that adventures of this sort are precarious, to say the least. They may be capable of very serious accidents, although we have no definite data on such accidents actually having occurred. That is a theoretical possibility, however, which cannot be dismissed. Perhaps one of the greatest objections to their use is the fact that this kitchen therapy may have the effect of tending to discredit the drug itself when properly produced. Physicians or laymen who would use this clandestine product are the type that would be very enthusiastic about results or very convinced of their worthlessness, as the case may be, when actually their experience is perfectly worthless because the product has no standing whatever.

We believe that ethical physicians should be content to stick by for a little while longer until the product is put on the market for civilian use. The rate at which companies are developing this industry would seem to indicate that surely before a great many months, or at least by the time the war is over, there will be an abundance of this drug for everyone. In the meantime it is possible to get some of the product at times for very important and severe cases. We believe that it will be better if we go along with the authorities until that time comes, rather than attempt a “shortcut” that may land in difficulty or even in disaster.

MAKING THE WHEELS GO 'ROUND

THE JOURNAL frequently comments on the activities of various groups connected with the Indiana State Medical Association. At times these remarks have to do with the goings on in the official family, such as some outstanding doing of one of our officers; at other times we have commented on the work of the Council and of the Executive Committee. On this occasion we wish to say a bit concerning one of our committees, one that was created not too long ago — the Permanent Study Committee on Health Insurance, of which Dr. Harry Howard is chairman.

This committee was first organized a few years ago and had made certain studies of the various plans in operation in many parts of the country, but no specific recommendations had been made to the House of Delegates. In January, President Oliphant, in addressing the mid-winter meeting of the Council, made it plain that he expected some tangible, direct results from this new committee; in other words, he "cracked down" on this and other committees, demanding that some definite plan be adopted.

We recently attended a part of a full-day session of the committee, and we were pleased to note the earnestness with which this group went about their business. They started their work with that safest of all premises — the feeling that they knew little about details and that they had a lot to learn. After a morning session they joined with the Executive Committee for a post-luncheon session that carried on for more than three hours.

They had invited an experienced insurance man to address them, discussing many of the intimate details of such an insurance program. By dint of questioning this man, the committee was able to pile up a lot of useful information for future conferences. It also was decided that the committee as a whole should make a visit to another state where such an insurance program is carrying on successfully, there to make a personal study of their program.

We know of no medical-economic problem that is presently more acute than this matter of health insurance and agree that the committee should make personal investigations of what is being done elsewhere in the country. We consistently have opposed the Wagner-Murray-Dingell Bill, which now promises to be a dud in Congress, and, having successfully opposed this, it becomes our duty to offer to the people of Indiana a workable substitute. There can be no question but that there is a demand for some such measure, the publicity given the Wagner-Murray-Dingell proposed legislation having been so general that the public is health-insurance conscious.

President Oliphant, in making his committee assignments, did so with a view to naming the best men available in the state for each of the positions;

personal friendships and geographical distribution played little part in these assignments. His first thought must have been, "Who will *work* on this or that committee?" He has done a good job, as we now view it, in the selection of this most important committee. Having seen them in action and having talked with many of them, we are prepared to say that their final report will be worthy of the study of every physician in Indiana.

This is but another example of small groups of busy medical men giving freely of their time and talents in the furtherment of organized medicine. And it does take time — each of the members of this committee gave a whole day to this purpose, and as the year goes on they will be called on for more and more such sacrifice. And it is our prediction that this additional time will be given unstintedly. This group is doing good work and will continue to do so. They are open to suggestions, and any of our members who have ideas on the subject would do well to get in touch with one of these members.

NOW IT CAN BE TOLD!

For a long time we have been hoping that some brave soul would intelligently discuss the subject of "hospital visitors," a matter that has been disturbing us for many years, yet we have felt hesitant about expressing ourselves freely. But now that Dr. Thurman B. Rice, executive head of the Indiana State Board of Health, has spoken "out loud" about it, we feel that the bars have been thrown down and that the subject is open to discussion.

In an editorial, "Concerning the Matter of Visiting the Sick," published in the January issue of the *Monthly Bulletin of the Indiana State Board of Health*, Dr. Rice speaks plainly on the subject, setting out some very cogent reasons why indiscriminate visiting of hospital patients is in bad order. He also admits that comment on such a question does little to improve the popularity of the writer, which is very true; so many folk will take offense at what is said, but that is because they do not know the inside of the matter.

He marshals his evidence in good style, beginning with the fact that "The average hospital patient needs every bit of strength he can muster." He is a sick individual, else he would not be in the hospital. One of the reasons that his physician sent him there was that he might have rest—more rest than the average patient gets in his own home. If rest be the requisite, why should he be pestered with a lot of visitors, most of whom are there more for curiosity's sake than for any other reason? A patient may desire the visit of some member of the family for a little while, on occasion, but there is no need for the entire neighborhood to feel an obligation to pay a visit to the sick person.

Dr. Rice also points out that too many visitors stay too long; this we of course know to be true. If the hospital visiting hours are from seven to eight-thirty o'clock, many visitors beat the gun and arrive several minutes to a half hour before the scheduled time, and remain for a similar overtime period.

Then, too, it is pointed out that the average hospital visitor is not very careful in his choice of conversational subjects. We have known of visitors to a pneumonia patient, for example, who sat alongside the patient and regaled him with stories of the recent death of a mutual acquaintance—"Yes, he died from pneumonia." Very cheering to the patient, that!

The shortage of nurses and hospital help also adds to the complications, and a lot of visitors means additional work for the hospital corps. If these visitors bring flowers, that also increases the burden of the nursing load.

Dr. Rice goes all out in his comment on the recent epidemic of infectious diarrhea of the newborn, which caused the death of so many infants and was responsible for the closing of the obstetrical departments in several hospitals for a varying period. He agrees that the causative factor has not as yet been isolated, but that it is most certain to be of the virus type, *and that it is quite likely that the infection is spread by older persons*, even though these persons are considered as being in good health. In other words, it is more than possible that this infection was brought into the hospital via the visitor route.

Practically all hospital authorities will tell you how happy they were during the recent influenza epidemic, when most hospitals excluded visitors except in rare instances. Patients got along better; the hospital staff functioned to a more efficient degree, and the nurses in particular were highly pleased with the new regime.

We are in entire accord with the closing paragraph of Dr. Rice's editorial, hence adopt it as our own. "We repeat that in our opinion *there is too much hospital visiting and too much sending of flowers to the sickroom*. Think it over before you write in and bawl out the editor."

WASTE PAPER

Rather an odd title, this, for an editorial in a medical journal, yet the subject is very apropos, as will be seen. The War Production Board has made the statement that "Waste Paper Is Our Number One Critically-Needed Raw Material!" The board has issued a bulletin on the subject that is illuminating, indeed, and offers suggestions that medical men and hospitals can carry out, much to the benefit of the war needs. In fact, the hospitals of America can do things in a big way in the matter of saving paper.

It is stated that the demand for paper is reaching unheard of tonnages, this two years after the beginning of the war, so far as we are concerned. A few of the most crying war needs for paper may be cited. It takes 25 tons of blueprint paper to make the plans for *one* battleship; a 500-pound bomb requires 12 pounds of paper to make the rings, tops and bottoms; each 75-pound shell takes 1.8 pounds of paper-board for its protective container; 700,000 different kinds of items are shipped to the Army, paper-wrapped or boxed; 52 pounds of paper are used in preparing an Army hospital ambulance for overseas shipment. We might carry on indefinitely, naming the many requirements for paper in wartime, but the above will suffice to show the real need for paper.

It is suggested that our hospitals can assist in two ways:

- (1) Avoiding waste in the use of paper.
- (2) Salvaging waste paper and returning it to use. These rules, of course, will apply to doctors as well.

Just how the hospital, in particular, can help out in a big way is evidenced by what several Chicago hospitals are doing. In one of the institutions an average of 6,000 pounds of waste paper is salvaged every month, this because of a change in their system of keeping records. In this hospital some half dozen rooms were required as storage space for old records, this in itself no little item of expense, besides occupying six rooms now made available for patients. This was made possible by micro-filming all records, which, of course, made an enormous saving in filing space. Other Chicago hospitals have adopted the plan, and still others will do so, so that in the end there will be an outstanding contribution to our waste paper pile.

Not only in this micro-filming program can hospitals help; they have old ledgers, old files, correspondence, et cetera, that might well be scrapped. Even old cancelled checks will add to the volume.

Physicians, too, can make notable contributions. At their offices they receive second-class mail every day—much of it is not even opened. They have old files that are long past the age of usefulness, old cancelled checks and whatnot. But it is in the homes that probably the greatest saving of waste paper can be made. We all get from one to a half dozen papers daily, and these, with the huge Sunday editions, make a sizeable pile of waste paper, to say nothing of the wrapping paper from the stores, old magazines, and even old books. If you have no means of getting these to the junk dealer, you can call the Boy Scouts, school children and many other agencies who will gladly call and pick up your scrap paper.

And while we are on the subject, we wish to suggest to the War Production Board that there still is an enormous waste in paper in many Washington bureaus. A lot of the printed material that is being sent out is of little value to the average

recipient. Only a short time ago *THE JOURNAL* received a letter from an agency, complaining because we had not used the material sent us—stating that unless we did better they would take us off their mailing list, which was quite agreeable to us.

Here, then, is one place where we can *all* play the game; it takes but little time to do the things asked of us, and it certainly will pay big dividends. **SAVE THAT PAPER!**

Editorial Notes

The scientific program committee has held a meeting, at which plans for the Indianapolis session were formulated. From the preliminary plans it is evident that the 1944 session will be up to the usual standard in the matter of scientific papers. Incidentally, it is not too early to be thinking about your hotel reservations for that event. Bear in mind that Indianapolis hotels are usually well filled up and that an early reservation assures you of the accommodations you wish.

Attention is directed to the Necrology report in this issue, prepared by Dr. James B. Maple, of Sullivan. The report does not merely give the name of the deceased physician, with a line or two as to his year of graduation and place of residence, but is an informative bit of reading. Dr. Maple spends no little time in checking each case as to accuracy, hence his report is far different from the usual "obit" report.

Dr. L. Y. Mazzini, of the Indiana University Medical Center and the Indiana State Board of Health, long ago devised what is known as the Mazzini Test for syphilis. This test long since has been accepted in most circles, but recently a new honor was bestowed on the discoverer when the United States Army specifically adopted the test. The Mazzini Test is under the control of the Indiana University Medical Center.

All members of the Indiana State Medical Association are invited to attend the Annual Industrial Health Conference, to be held at the Indiana University School of Medicine on April 19-20. The published program indicates that much of unusual interest will be provided, speakers from all sections of the country having accepted invitations to appear. This Conference, rather new to Indiana, already has taken front rank as an outstanding presentation of all that is best in furthering the health program of American industry.

A forthright statement by Meredith Nicholson appeared in the column "Without Prejudice," of the *Indianapolis Star* of March 20, against the federalization of medicine. Thanks, Nick!—coming from you, this statement will carry great weight with your many Hoosier readers and admirers.

Several state medical officials, and not a few medical editors, evidently do not take kindly to the off-hand remark of an official of the American Medical Association to the effect that lay secretaries, both state and county, too often go far afield in their activities. We cannot agree that this is true, our observation being that the most active county and state organizations, the groups that get most things done and get them done handsomely, are those that employ full-time lay secretaries.

Along about the first of March the question, "Who saw the first one?" appears to be current, meaning the first robin redbreast. But it remains for the *Lowell Tribune* to pull a new version, the story having to do with bluebirds. A local resident vouched for the story that he noted the passing, overhead, of a plane, and that he saw some bluebirds hop out of this plane, fly down to earth and alight on a nearby fence. Another resident is quoted as having seen some bluebirds minus the plane—he just saw 'em.

Now comes the American Bar Association with a direct hit at the Wagner-Murray-Dingell Bill. In a lengthy but thorough analysis of the measure, this association points out its many evils. However, the fact that such organizations have lined up with us in the matter does not mean that this is the end of the dangerous bill. It is more than unlikely that the bill will receive the Congressional nod, but such defeat will in no wise deter those who seek our undoing; there will be other measures in time to come, measures that are just as dangerous as the one presently receiving our attention. Now that we are organized against such legislation, it is up to us to maintain that organization intact; we will again have use for it.

The new address of *THE JOURNAL* is 1017 Hume-Mansur Building, just down the hall from the former location. The telephone number is Franklin 3895. In recent years the activities of your official magazine have increased to such an extent that more space became necessary, and the recent move is the realization of a long-continued dream of *THE JOURNAL* staff. The state of things had become such that we got in the way of one another in our former cramped quarters, and we worked under handicaps. However, we now have more room and a much better arrangement in which to carry on our work. Drop in and look us over in our new home.

Garden note: Several vegetables may safely be planted in early April, even in the northern sections of Indiana, such as beets, spinach, lettuce, and green onions. We usually beat the gun by seeding this group at that time provided the ground can be worked. Dividends are quite satisfactory, too.

From present indications the June meeting of the House of Delegates of The American Medical Association, in Chicago, will be a most notable one. It is apparent that many sections of the country are not wholly pleased with the interpretation placed on the acts of the 1943 House by various official heads of the parent body; hence, it is expected that some of the delegations will have somewhat to say on the subject. "Rumblings," the word used by the editor of the medical journal of one of the southern states, are rife and it is expected that these so-called "rumblings" will crystalize into something a bit louder than mere groans.

In the passing of Dr. Hugh A. Cowing, of Muncie, the Indiana medical profession has lost one of the few remaining old-time exponents of the highest ideals of the profession. Eighty-three years of age, Dr. Cowing retained his active interest in all that went on in Indiana Medicine. He had his notions about medical affairs and knew how to express them. We cherish several letters we have received from him as of rather recent date, in some of which he had disagreed with certain of our writings, but in the main he was in accord with what the Indiana profession is trying to do. For many years the head of the Indiana State Board of Health, later serving as health officer in his home city, he was in the van in the matter of what constituted good health measures. Like the late Dr. William A. Spurgeon, also of Muncie, Dr. Cowing was active in the affairs of his church and for many years conducted a large Bible school for men.

Some time ago we commented on the work of the Bartholomew County Circuit Court Judge who seemed to have his own notions regarding law enforcement, and accordingly meted speedy justice to all who were brought before him. Now our attention is directed to another Indiana Circuit Court, that of Tippecanoe County. Judge W. L. Parkinson presides over this court and found that when he opened court for the present term there was not one criminal case on the docket. Tippecanoe County is not one of our small country communities; it boasts of a population of some fifty thousand, its county seat being Lafayette, a city of thirty thousand inhabitants, hence the record is all the more impressive. These two counties serve as an index of what law enforcement will do in the matter of crime prevention; some of our larger counties not only have a continuous criminal docket, but find it necessary to have separate courts to handle these cases.

When Colonel McCormick, editor and publisher of the *Chicago Tribune*, goes after something, he steps out and goes all the way. Just now the *Tribune* is getting after the State of Indiana, charging that we are responsible for the insanitary condition of lower Lake Michigan, due to industrial and urban wastes of Lake County cities having been dumped into those waters in years past. In a recent scare-head news item, the *Tribune* grows quite hysterical about the typhoid fever epidemic up around Peru; says that the waters from this area will further pollute Lake Michigan, and that we can look for plenty of typhoid fever in Chicago-land in a short time. Land sakes, colonel, have you looked at the map? The surface drainage from the Peru neighborhood is *away* from Lake Michigan; it goes down the Wabash River!

We have refrained from comment on the typhoid fever epidemic that recently prevailed in northeastern Indiana, principally around Miami County, for several reasons, chief of which is that it is the policy of THE JOURNAL not to engage in speculative writing. We prefer to discuss such matters after the Indiana State Board of Health has completed their investigations. Now that the local press has taken up the matter, it seems that comment might be in order. The *Peru Tribune* issue of Monday, February fourteenth, carries a statement prepared by the State Board of Health, in which it is rather definitely stated that the source of the infection had been found—a food product manufactured and sold largely in that neighborhood. The board compliments the members of the local profession and the nursing staff of that area for their indefatigable efforts to further the investigation. It is hoped that a formal, complete statement of the facts in the case may later be presented in THE JOURNAL by the Indiana State Board of Health.

An Indianapolis physician is declared to have refused to sign a birth certificate because the medical bill had not been paid. This, quite naturally, raised a considerable hullabaloo, and the local press hopped onto the story with great interest. The Indianapolis Medical Society made an immediate investigation and found several interesting facts, first of which was that the physician in question was *not* a member of the local society. The matter was further complicated by the fact that the father of the child had been inducted into the Army and that the mother had not been able to obtain the monthly allowance of twenty dollars because she could not get a birth certificate. However, the local Chapter of the American Red Cross got on the job, a certificate was obtained and all was well so far as that matter is concerned. We might launch into several diatribes over the incident, but will content ourselves with the observation that such acts bring condemnation on the entire profession. They do the offender no good; in fact, they properly classify him as a rather thoughtless individual.

The March eleventh number of *The Journal of the American Medical Association*, in a report from the Council on Medical Service and Public Relations, pays our state association a rather pleasing compliment, one that is highly deserved. The comment is as follows: "The Council studied the speaker's kit compiled by the Indiana State Medical Association in its fight against the Wagner-Murray-Dingell Bill and considered it an excellent collection of material, and invites the attention of the other states to what Indiana has accomplished in this regard." They refer to the "kit" passed out at the speakers training program at the recent Secretaries Conference, in Indianapolis.

We have been interested in looking over a little brochure regarding AMBAC, meaning the American Bureau for Medical Aid to China. This organization appears to be doing a good work, one that should commend the interest of all medical men in this country. The long list of directors includes the names of American and Chinese folk, many of them well known to us. The organization was founded some four years ago, and since that time has made marvelous strides. In 1943 AMBAC sent over a million dollars in cash to China, this for health purposes. In addition, more than \$75,000.00 in supplies was sent over there. The organization gives inoculations against such diseases as cholera, typhoid, smallpox, et cetera. They see to the disinfecting of various sources of water supply, and also see that food is properly handled. A spare dollar or so will go far toward advancing the work of this important organization, whose headquarters are at 1790 Broadway, New York City.

We have received a complaint letter, and are inclined to agree with its contents. The opening statement of the letter says, "Have you noticed, lately, that radio commentators and announcers are paving the way for socialized medicine? They announce that the surgeon general of the United States says so and so." Yes, we have heard just that sort of thing on many occasions and agree with the writer that the statement is not correct. In the first place there is no "Surgeon General of the United States"; we have a Surgeon General for the Army, one for the Navy, and one for Public Health—all separate divisions. From our observations it seems that these pronouncements come from the office of the Surgeon General of Public Health. We do not mean that Doctor Parran refers to himself as the Surgeon General of the whole country when he authorizes statements to be used over the radio, but someone blunders when that impression is given. Steps should be taken to correct the evil, which evil, by the way, opens up some speculation as to *what might happen if the public health director should become the real boss of medicine.*

Governor John W. Bricker, of Ohio, a candidate for the Republican nomination for President, has spoken in unmistakable terms against the socialization of medicine. The *Ohio State Medical Journal*, in the April issue, contained an editorial commenting upon Governor Bricker's standing concerning such proposals as the Wagner-Murray-Dingell Bill. The editorial is reprinted herewith:

PROPOSALS FOR FEDERAL MANAGEMENT AND REGIMENTATION IN FIELD OF PUBLIC HEALTH ASSAILED
BY GOVERNOR BRICKER

"Governmental management and regimentation which would become necessary under a program such as the one proposed in the Wagner-Murray-Dingell Bill would 'inevitably lead to national chaos and disorder' and be 'a distinct threat to the future health of our people,' Governor John W. Bricker, of Ohio, warned in an address before the Creve Coeur Club of Peoria, Illinois, at that organization's annual Washington's Banquet on February twenty-second.

"Although Governor Bricker, who is a candidate for the Republican nomination for President, did not refer directly to the Wagner Bill, he left little room for doubt that he had that proposal in mind when he lashed at current movements to give the Federal Government complete domination over the field of public health.

"Charging the Federal Government with 'extreme busy-bodying and meddlesomeness in many affairs that ought to be left to the people themselves,' Governor Bricker stated that in his opinion 'our institutions of free government are threatened as never before' because of existing bureaucratic, paternalistic and dictatorial policies and trends.

"'It should be the function of government to serve the people, to help them help themselves,' he said. 'It is not the function of government to direct every act of the citizen in his daily life. To make matters worse, this administration has not gone as far as it wishes to go in the regimentation of our daily lives.

"'Consider, for example, the field of public health. Whatever governmental attention is proper or desirable in this field can be given much better by the states themselves or by private agencies who are closer to the people and have a better grasp of the problem.

"'The American doctors have made eminent progress in caring for the health of our people. Medical organizations and private hospital groups are making substantial progress toward the goal of providing adequate medical and hospital care for all.

"'In view of this record, I regard the proposals emanating from this administration for governmental intervention between the doctor and his patient as an undeserved affront to a loyal and admirable profession and a distinct threat to the future health of our people.

"'It is these meddlesome activities in so many spheres that properly belong to the states or to the people themselves that have led to the multiplicity of government agencies which are unsupervised and uncontrolled, and which it is impossible to supervise or control. These virtually autonomous agencies were set loose upon the people with unlimited funds; and the people, in pursuing their peace-time affairs, were sorely beset in trying to accommodate themselves to the disorder. It was one of the significant reasons why we failed to achieve a sound, economic recovery before the war.

"'Please do not misunderstand me. Government must be responsive to the needs of social progress in every field. It must continue to be. Human welfare means more than good intentions and material help. It must promote education, health, and public welfare. But it must leave to individual human beings a full measure of control over their own destiny. Governmental management and regimentation inevitably lead to national chaos and disorder.'"



President's Page



The Council of the Missouri State Medical Association passed a resolution opposing the Wagner-Murray-Dingell Bill, and sent a copy of it to Senator Harry S. Truman. Senator Truman's reply said in part, "I am not for socialized medicine. However, it is up to the doctors themselves to reinstate some sort of a country-doctor system or some sort of a mass medical system so the common ordinary man can have access to able and well-qualified physicians. Things have gotten to a point in specialized medicine, which is just as bad as socialized medicine, that the ordinary citizen is in the position of having to do without because he can't afford a specialist. I think it is up to the doctors themselves to work out the situation, because if they don't we are going to have socialized medicine."

The senator has in mind the general practitioners of some two to four decades ago. These men practiced almost exclusively in the homes of their patients. They seldom sent anyone to a hospital except for surgery. The diagnosis was made solely by observation, and such was the doctor's confidence in himself that a consultant was rarely called. He covered the entire field of medicine, so there was no occasion for the services of a specialist.

We can understand the senator's sense of loss. We, too, deplore the passing of these grand old men. They brought to the sick room an air of cheerfulness and optimism that filled the patient with confidence. These were assets to the invalid although they were sometimes founded upon a tragic error of diagnosis.

The modern doctor is concerned primarily with the cause of his patient's illness. To discover this frequently involves hospitalization for closer observation, laboratory and x-ray exploration, and if the disease is one that has been especially studied by a group of men, one of this group is usually consulted. All of this increases the cost to the patient, but it pays off in results.

The senator knows this; he knows, too, that few people object to paying for necessary diagnostic procedures. He is merely voicing an irritation sometimes expressed by people who feel that they have been over-charged for medical service and who blame the entire profession for it.

There was never a time when "the common ordinary man" could have access to a better qualified or more able physician than now. "The common ordinary man" needs the services of the trained specialist as much as any other kind of man. "The common ordinary man" is now and has been receiving these services.

Nothing complained of by Senator Truman will bring about socialized medicine. The forces seeking to socialize medicine are the forces that are seeking to substitute socialism and communism for democracy. Some of the things complained of may make it harder to combat socialized medicine because they are destroying the friendship many people have felt for their doctors.

We admit that occasionally some member of our profession who has gone into a specialty has acquired a bloated and unhealthy opinion of the value of his services. The lack of competition has made it possible for him to give way to greed. He not only demands more than his capabilities justify, but he is offensive enough to require the payment in advance.

Certainly it is in keeping with the best traditions of medicine for a doctor to have a sympathetic understanding of his patient's ability to pay. No conscientious doctor will recommend any measure that is not necessary for the patient's good, nor will he refer a case to any specialist who is actuated by greed and avarice. Should he do these things, he is guilty of being an accessory to a crime against his fellow physicians.

It is only by the most careful regard for the rights and feelings of their patients that the doctors can win back the good will which Senator Truman's letter indicates has been lost.



SECOND ANNUAL INDUSTRIAL HEALTH CONFERENCE OF THE INDIANA STATE MEDICAL ASSOCIATION

April 19 and 20, 1944

Auditorium

Indiana University School of Medicine

Indianapolis

Wednesday, April 19, 1944

Morning Session

E. S. Jones, M.D., Hammond, Chairman, Committee Industrial Health, Indiana State Medical Association, presiding.

9:00 Registration—No fee.

10:00 Opening Remarks, E. S. JONES, M.D., Hammond.

10:10 **"Obligations of the State Medical Association in the Training of Industrial Physicians."**

J. T. OLIPHANT, M.D., Farmersburg, President, Indiana State Medical Association.

10:20 **"Obligations of the University in the Training of Industrial Physicians."**

W. D. GATCH, M.D., Indianapolis, Dean, Indiana University School of Medicine.

10:30 **"Post-War Industrial Health Problems."**

R. L. SENSENICH, M.D., South Bend, Member, Board of Trustees, American Medical Association.

10:45 **"Medical Records and Record-Keeping in Industry."**

S. L. RANKIN, M.D., Charlestown, Medical Director, Indiana Ordnance Corporation.

11:30 **"Occupational Acne."**

SAMUEL PECK, M.D., Bethesda, Maryland, Senior Surgeon (R), United States Public Health Service, Division Industrial Hygiene.

12:30 Lunch.

Afternoon Session

Lieutenant Colonel Raymond Hussey, M.C., Baltimore, Maryland, Director, Army Industrial Hygiene Laboratory, Johns Hopkins University, presiding.

1:30 **"Disability Evaluation."**

EARL D. McBRIDE, M.D., Oklahoma City, Oklahoma.

2:30 **"Treatment of Hand Injuries."**

SUMNER L. KOCH, M.D., Chicago, Illinois.

Intermission

3:40 **"Preventive Medicine in Industry."**

JOHN H. FOULGER, M.D., Wilmington, Delaware, Director, Haskell Laboratories, E. I. DuPont Company.



S. L. Rankin, M.D.



Samuel Peck, M.D.



Sumner L. Koch, M.D.



John H. Foulger, M.D.

Wednesday, April 19, 1944—Continued

Evening Session

Indianapolis Athletic Club

6:30 Dinner.

"Value of Industrial Medical Services in Industry."

VICTOR HEISER, M.D., New York City, Medical Consultant to National Association Manufacturers.



J. G. Townsend, M.D.



O. A. Sander, M.D.

Thursday, April 20, 1944

Morning Session

J. G. Townsend, M.D., Bethesda, Maryland, Medical Director, Chief, Division Industrial Hygiene, United States Public Health Service, presiding.

9:00 **"The Importance of Fungus Infections in Industry."**

SAMUEL PECK, M.D., Bethesda, Maryland, Senior Surgeon (R), United States Public Health Service.

10:00 **"Prevention and Treatment of Silicosis with Aluminum."**

D. A. IRWIN, M.D., Pittsburgh, Pennsylvania, Medical Director, Aluminum Company of America.

Intermission

11:10 **"A New Technique in Drawing Blood for Serodiagnostic Tests: Use of the Hemospast."**

KENNETH E. MARKUSON, M.D., Lansing, Michigan, Director, Division Industrial Hygiene, Michigan State Board of Health.

11:30 **"Lung Changes in Electric Arc Welders."**

O. A. SANDER, M.D., Milwaukee, Wisconsin, Medical Consultant to Industrial Hygiene Foundation.



Verne K. Harvey, M.D.

12:30 Lunch.

Afternoon Session

Symposium on Rehabilitation and Employment of the Handicapped Veteran.

Colonel A. J. Lanza, M.C., United States Army, Washington, D. C., moderator.

1:30 **"Present-Day Employment of Physically-Handicapped Under Federal Civil Service."**

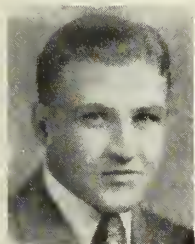
VERNE K. HARVEY, M.D., Washington, D. C., Medical Director, United States Civil Service Commission.

2:30 **"Putting the Veteran Back to Work."**

A. A. HENDRIX, Linden, New Jersey, Personnel Director, Eastern Aircraft Division, General Motors Corporation.

3:30 **"Community Organization for Rehabilitation and Re-employment."**

HAROLD VONACHEN, M.D., Peoria, Illinois, Medical Director, Caterpillar Tractor Company.



Kenneth E. Markuson, M.D.



Harold Vonachen, M.D.

CANCER CONTROL

MRS. RONALD M. HAZEN

State Commander, Indiana Division of the Women's Field Army

INDIANAPOLIS

The Indiana Division of the Women's Field Army of the American Society for the Control of Cancer is participating this month for the seventh consecutive year in the annual nation-wide educational and enlistment campaign.

With the guidance of the state and local medical societies, we are attempting to form units in every county in Indiana. We may not be able to accomplish all the things we hope to this year, but we are well on our way.

We endeavor by every possible means to inform the public about the early signs of cancer, and to emphasize the fact that prompt, proper treatment in the early stages of the disease could save many of those who now die from it.

Every available avenue of communication to the public is used: newspapers and magazines, the radio, lectures, free leaflets, exhibits—a poster contest which has just been completed in one county—and through motion pictures, such as "Enemy X" and "Choose to Live," produced by the Women's Field Army in conjunction with the United States Public Health Service. Most of the educational literature is prepared in the National Office of the American Society for the Control of Cancer. However, this year Dr. Thurman B. Rice, Indiana's State Health Commissioner, has prepared for us a very informative leaflet for wide distribution in the defense plants.

There has been a growing demand all over the country for cancer education in our schools and colleges. The value of such education was first realized by Dr. H. R. Carlton, of the Westchester County (New York) Cancer Committee. His booklet "Youth Looks at Cancer," recently published, marks the beginning of a plan to present the subject to the adolescent mind in a way that will prove useful in later life. A copy of the book has been sent to every school library in Indiana by our Women's Field Army.

We have over two thousand "soldiers"—women volunteers—in the Women's Field Army in Indiana. Many have worked in our organization from its beginning. Maintaining the interest of our workers in a purely educational program has been found to be somewhat of a problem. There is a constant urge to accompany this somewhat intangible program of education with a tangible project. This has been partially provided in donations of instruments and equipment to clinics wherever there is a definite need.

In the past two years, three diagnostic clinics were held in smaller county seats. About twenty-five patients presented themselves at each clinic. The clinic examination consisted of a history taken

by one of the doctors, and then an examination suitable to confirm or rule out the question of cancer in the patient's complaint. A complete general examination was not attempted. In case there did not appear to be any malignancy involved, the patient was advised to see the family physician.

In cases where definite diagnosis could not be made without recourse to laboratory, x-ray or other consulting service, the report was made out by the examining physicians and sent to the patient's family doctor with recommendations for further study or treatment, to confirm or rule out malignancies. With a little organization, two or three physicians, a couple of nurses, and one or two clerical workers can handle twenty-five or thirty patients in about two hours. The reports are written in long-hand and later are typed, the original being sent to the patient's doctor, the duplicate remaining in the sponsoring hospital in a confidential file, and the long-hand copy going to the state office of the Women's Field Army, to be placed in a confidential file.

These clinics were held in cooperation with the local Women's Field Army. They were sponsored by the county hospital, from where letters were sent to all staff members and all physicians of the local county medical societies, asking them to participate in the work of the clinic and to send or bring in patients for examination. It was emphasized that cases which had already been examined or treated for cancer should not be sent in. Publicity was handled through county papers and was all built up around the sponsoring institution. No physicians' names were used, and at the time the patient was examined very few of them knew the names of the doctors who were conducting the examination.

The benefit to cancer-control measures in general through the service of special diagnostic clinics was particularly brought out at the Women's Field Army Institute held recently. Dr. Arthur H. Curtis, professor of Gynecology at Northwestern University, attributed the markedly-improved results of recent years, as compared with past experience, to popular education. "Noticeably-earlier cases are seen nowadays in clinics throughout the country. Patients voluntarily present themselves for diagnosis and treatment; they have been educated to this point largely through measures carried out by the Women's Field Army," said Dr. Curtis.

It is hoped that the physicians of Indiana will cooperate in establishing a clinic in each county or district; the clinic to be under the direction of the local county medical society in each instance.

In accordance with the State Medical Association House of Delegates' approval of diagnostic tumor clinics, such steps have already been taken in several communities. The movement to establish diagnostic clinics in Indiana is part of a nationwide effort on the part of the American College of Surgeons to establish cancer clinics throughout the country.

The Indiana University Medical Center has an approved or so-called "Grade A" clinic, and the Tumor Clinic at the Indianapolis City Hospital is also adequately equipped. The only other cancer clinic in Indiana, on the approved list, is the one at the Deaconess Hospital at Evansville.

In the United States, eleven states have a "Cancer Commission" program. Three of the states, Missouri, Massachusetts and New York have cancer hospitals under government control.

There is much to be done in coordinating cancer activity throughout the state. Long-range planning and stabilized financing are of prime importance. Many questions before us are not conclusively answered, but this much is clear: the cancer control program within our state calls for utmost individual endeavor to bring out cancer facts and give cancer a place in health work more in line with its importance.

MEDICAL PUBLIC RELATIONS—SOME OBSERVATIONS*

JOHN E. FARRELL†

PROVIDENCE, R. I.

Concerning medical public relations in the New England States, I doubt that I can report anything new or more effective than what has been tried elsewhere, and I infer that the request that I mention the subject at all is predicated on the fact that the Northeastern states issued a joint declaration last December on the Wagner Act.

Representatives of the six state medical societies assembled at Boston and went over the details of the Wagner Act. We wisely concerned ourselves exclusively with the medical proposals in the proposed legislation, and after lengthy deliberation produced a statement which is probably without equal from a medical group in the country today on this particular legislation. As it was reprinted in your Journal this month as an open letter from the Massachusetts Medical Society, I commend it to your reading.

As a form of public relations, I think it is outstanding as a definite statement of willingness to sit down with representatives of federal or state government to work out plans to improve the health of all the people. There is no damning of Wagner and his co-sponsors, no threat of socialized medicine cited, no czarism from the public health service head suggested, nor any fear expressed that private medicine, as we know it, faces its doom. On the contrary, the statement of the New England group represents constructive thinking and, to our way, it is the only solution by which we may assure the public that we are not only ready but quite willing to accept responsibility in furthering community health programs which will protect the individual.

Neither the editor of the *Journal of the American Medical Association* nor the new council on Public

Relations agreed with the statement exactly as it was written, and although both offered changes in the wording, the New England groups were emphatic in maintaining their original stand. And that is the way it should be in such matters, for the sound thinking on the local level by persons best acquainted with the local conditions cannot be easily put aside for a national policy.

The success of the meeting of the societies last fall has prompted the Rhode Island Medical Society to propose a New England Council to consist of the president and two other representatives of each society to meet at least three times a year to discuss mutual problems affecting medicine and public health. By joint action we may be able to accomplish what is impossible individually.

When I think of the excellent work that has been done, not only here in your state but about the country, by your Association, and particularly by your ambassador of good will, Tom Hendricks, and of the exhaustive work done by your Doctor Forster in Lake County with his survey of public opinion, I think I should sit down right now and not attempt to say anything further on this matter of public relations. But I come from a state where there is inscribed on the front of the state house the expression, "Rare felicity of the times when it is permitted to think as you like and say what you think." With that assurance I shall offer a few concluding remarks.

An outstanding public relations expert once told me that if every county medical society in the country were to take advantage of local opportunities to place themselves in a preferred position in the eyes of the public, by letting them know what they have done, we would have no problem of the government trying to take over the practice of medicine. I doubt that he is wholly correct in that supposition, but I agree with him in part. The general practitioner of

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, January 23, 1944.

† Executive Secretary of the Rhode Island State Medical Society.

the by-gone day knew the secret of public relations, and as a result his status was always A-1 in the community.

But modern living and modern medical practice have altered medical public relations. What the doctor did in public relations as an individual a generation ago, now must be done by his medical society as a unit in molding public opinion for the good of the medical profession. For one thing, I firmly believe that medicine faces a tremendous task of public relations within its own ranks, for too few of our doctors know intimately of the problems facing the profession in general, and too few are willing to assume the obligation of active service on committees of their own society, to say nothing of the more important role of active membership and leadership in community organizations.

I hesitate to speak for New England at this point, but I can tell definitely of the pattern we are pursuing in Rhode Island. We construe this matter of public relations as community leadership in anything that touches medicine and health. As a result, we try to anticipate where our services may be needed, and we not only offer to take a seat at the council tables of the various planning groups—we are ready to demand such representation if necessary. And we don't go in always with the idea that organized medicine is perfection. We admit room for improvement, but at the same time we insist on the privilege of making the improvements that affect us.

The proposed hospitalization program of which I have spoken would undoubtedly make the medical profession hysterical in some parts of the country. We do not yet know whether it is good or bad for the public, but we are soon going to find out because we have taken the initiative from government, and we are calling together leaders from all over the state to study this and all other plans being considered.

A year ago the state created legislation to provide for a rehabilitation center, paid by tax on insurance companies writing workmen's liability insurance, and on self-insurers, whereby injured workmen may be treated for return to their jobs as soon as possible. The state medical society had the legislation amended prior to its passage to provide by law that a medical advisory committee be established and to provide that the council of the society shall have the final approval of the selection of a medical director for this new state-community enterprise. The society desires no administrative control, and it made its position clear on that point, but it did demand the right to say by whom and how the medical phases of the program shall be carried out. That is not a work of legislation; it is sound public relations, for it established the medical profession as the authority that must represent the general public in safeguarding the medical care or any care allied to it.

The problem of industrial health illustrates another example. There is a New England Society of Industrial Physicians which has rigid rules, stipu-

lating as one requirement that a doctor be engaged full time in industrial work. That did not fit our plans, and we knew there was definite need for leadership in industrial medicine in our highly-industrialized state. As a result the Committee on Industrial Health of the State Medical Society sponsored a Rhode Island Society of Industrial Physicians and Surgeons which meets monthly, exchanges ideas on industrial health work, and already is contributing immeasurably to the leadership in industrial medicine. We have not a full-time industrial physician in the state, yet the membership of this new society exceeds that of the New England Society.

I could go on citing other examples. I might tell you how we have anticipated the problem of job transfers faced by the War Manpower Commission and have joined hands with that authority to set an example of cooperation that is performing wonders. I could relate how we moved into the state O.P.A. program with a committee which devised an all-inclusive form for supplemental rations for which a physician's certification is required, and of how that committee serves as a clearing bureau for the O.P.A. on all claims contested by local boards, with its decision final. I might mention how we have told the public frankly of the physician shortage, and how we have set up a program for the State Council of Defense whereby a leaflet giving instructions on how to help the doctor during these trying times, and how to protect personal good health, is being placed directly in every home in the state this month. I could spend time relating how we are co-operating with the public assistance authorities in an experiment whereby cash is being paid in one community to indigents with which they may purchase necessary medical care, just as it is given them for the purchase of rent, heat and food; and how we are ready to go further and meet the offer of the state to provide medical and hospital care for all who may be declared to be medically needy.

You can call these committee activities by any other name you wish, but they all sum up to one thing—good public relations for medicine. And the sooner we disabuse ourselves of the idea that community service is merely an invitation to have representation, and the sooner we recognize in it the opportunity to take a progressive leadership and thereby to convince the public beyond question that the administration of medical and health matters by the medical profession is most desirable, the better chance organized medicine will have to control its future destinies.

What is suggested from a national plane can be done far better on a state level, but unless medical leadership in each state will accept the responsibility every day of the year, and not merely wait upon the action of the national assembly of medicine once a year, others will do our planning for us. And unless we think ahead of the Federal Government with respect to future social security programs, we might as well stop talking about state's rights in medicine, as well as everything else.

SOCIAL SECURITY BOARD STUDIES MEDICAL CARE PLANS

F. K. HELSEBY

Director, Group Hospital Service, Inc.

KANSAS CITY, MISSOURI

In what is perhaps the most accurate compilation yet made, the Bureau of Research and Statistics of the Social Security Board has issued an analysis of the prepayment medical care organizations operating in the United States and Canada. The various plans are classified by these types of sponsorship: industrial; medical society; private group clinic; consumer-sponsored, and governmental.

Doctors generally will be surprised to know that there are 219 plans in these categories and that over 3,000,000 persons are eligible for care in accordance with specific benefit provisions. As one would assume, the industrial plans predominate, numbering 114. There are presented 25 private group-clinic plans, 31 consumer-sponsored plans, 35 medical society plans, 12 governmental set-ups, 11 plans in Canada, and 3 unclassified plans.

In no instance are any commercial insurance company offerings listed either in the field of health and accident or in the field of Workmen's Compensation, nor are the 77 Blue Cross Hospital Plans included. Also

excluded are plans administered by the Farm Security Administration and student health services as operated by the various colleges and institutions.

Almost uniformly, the industrial plans exclude services for dependents of the employed person. This exclusion has long been a weakness of railroad medical or hospital plans, and this trend is quite noticeable in so many of the larger industrial operations.

Many of the private group-clinic plans include services for dependents, but usually on a reduced benefit basis. Medical society plans include dependent coverage on an equal basis as provided for the employed person. The outstanding examples of this type of plan are: Michigan Medical Service, now protecting over one-half million Michigan residents; California Physicians' Service (surgical plan) with approximately 50,000 persons covered;

Surgical Care, Inc., of Kansas City, with 10,000 persons covered. It should be recalled that the Michigan Plan, operating state-wide, is four years old; that the California Physicians' Service is approximately four years old, and that the Surgical Care program operating in the Kansas City area is in its eighth month of operation.

There are many other interesting facts in the Social Security Board's study, ranging all the way from the data given for the Elizabeth Hospital Medical Service Plan, Prairie Grove, Arkansas, as a private group clinic with twelve subscribers, to the program outlined as covering the benefits of the Health Plan of Richmond Shipyards and Permanente Hospital, Mr. Kaiser's industrial plan.

The study made by the Social Security Board has apparently been carefully done, yet what is badly needed is a comprehensive survey of the entire field of protection and the general cost of illness. The medical profession should have up-to-date information as to the total percentage of our population having

FEDERALIZED MEDICINE

By Meredith Nicholson

"I confess to a fear of federalized medicine. If the government added this to its numerous bureaus, the loss in the professional standards would be incalculable. The American doctor has no superior and few equals anywhere in the world. The idea of socialized medicine impresses me only by its mischievousness. One of its worst features, apart from the blow to the individual's right to choose his own medical attendant, is the lessening of the doctor's incentive to carry on his studies beyond the point where he may be licensed to practice.

"I am sure many citizens share my feeling that doctoring is a very personal affair. We don't want the government assigning our doctors to us. We want the most skilled we can get and not such as some bureau official thinks is best for us.

"I consider the proposed Wagner-Murray-Dingell legislation for socialized medicine one of the worst measures proposed in recent congresses."—*Indianapolis Star*, March 20, 1944.

protection in one form or another, as covered not only by the type of plans as set forth in the study of the Social Security Board, but also in the field of individually- and group-purchased commercial insurance in the classification of health, accident, hospitalization, disability and surgical benefits, and also the various types of protection, including the 14,000,000 now protected by the Blue Cross Plan and an unknown number which may carry hospitalization and other benefits through fraternal organizations or various other methods.

We are seeing, and expect to continue to see, an accelerated demand for medical, surgical and hospital insurance — social insurance, if you prefer the terminology — primarily because of the absence of, or the inadequacy of, proper protection for the dependents of the employed person, residents of rural areas, and those not gainfully employed.

Military News

Captain Fred O. Clark, of Syracuse, is a flight surgeon at Fort Riley, Kansas.

Captain Frank Albertson, of Trafalgar, is now serving in the Fiji Islands. He is starting his third year of overseas duty.

Captain Robert L. Armington and Captain Roger R. Reed, both of Anderson, were recently home on leave of absence. Captain Armington has been stationed on the West Coast, and Captain Reed has just returned from the Aleutian Islands.

Dr. John McBane, of Fortville, is now located at the United States Maritime Officers' Training School, at Alameda, California.

Lieutenant Colonel Donald D. Johnston, of Fort Wayne, has been assigned to the Veterans' Administration, at Des Moines, Iowa. He was formerly on duty at Camp Atterbury, Indiana.

Captain William H. Hutto, of Kokomo, has been transferred from Scott Field, Belleville, Illinois, to Truax Field, Madison, Wisconsin.

Captain Clarence Laubscher, of Evansville, who was ordered overseas last July, is serving with the Air Force in England. He is reported to have attended medical sessions at Cambridge and Oxford Universities. According to letters received by his family, he has had some very interesting experiences since leaving the U.S.A.

Captain James G. Shanklin, Hammond, Air Medical Examiner, stationed at Harlingen Army Air Field, Texas, has been awarded his "Wings," an honor coveted by all men in that branch of the Army service. He has been commissioned as flight surgeon.

Promotion of a Terre Haute physician, Dr. William O. Baldrige, of the Army Medical Corps, to the rank of major, has been announced. Major Baldrige is at Camp Anza, Arlington, California, where he is a surgeon on the staff of the Station Hospital. Congratulations, Major Baldrige!

Major Irving Mishkin, of Elkhart, is at present stationed at Camp Stoneman, Pittsburg, California. His work there consists of training medical units.

Dr. S. W. Litzenberger, of Anderson, has been advanced to a commander in the Navy Medical Corps. Commander Litzenberger is now stationed at the Philadelphia Naval Hospital, in Philadelphia.

Captain Eugene C. Murphy, of South Bend, has been promoted to a major in the Army Medical Corps, according to a War Department announcement.

Captain Malcolm E. Miller, of Goshen, is in charge of a fifty-bed wing at the United States Coast Guard Training Station, at Manhattan Beach, Brooklyn, New York.

While in Indianapolis on detached service for five days, Captain Virgil McCarty, of Princeton, dropped in at headquarters. He is with the Station Hospital at Camp Howze, Texas.

After being in Africa, Captain Casimir Libnoch, of South Bend, is now in Italy. He said he was not too sorry to leave that place—"Quarters in towns are fairly comfortable, but in pursuit of duty I got in a touch with mud. SOME mud! Ankle deep and gooey! Slit trenches are filled with chocolate pudding into which of necessity one must dive."

Lieutenant Commander Harry Slominski, M.C., of South Bend, has been transferred from the Pacific War Zone to new duties at the Naval Reserve Midshipmen's School, at Notre Dame. Lieutenant Commander Slominski served aboard the Saratoga, as chief physician, and arrived at Pearl Harbor soon after the Jap raid, but most of the engagements he saw were in the Guadalcanal area. Five stars decorate his service stripes.

In a letter from Captain Naf H. Gladstone, of Fort Wayne, he says, "I happen to be the commanding officer of a medical hospital ship platoon, and in that capacity have had the opportunity of doing quite a bit of traveling. We have been in all the three major theatres of war, have been more than three-fourths of the way around the world, and have crossed the equator twice. At the present time we are stationed somewhere in Egypt. In my travels I frequently run across one of the Indiana medicos, and you know what happens when two Hoosiers get together, far away from home."

Captain William Paff, of Elkhart, has been promoted to a major. Major Paff is in Panama.

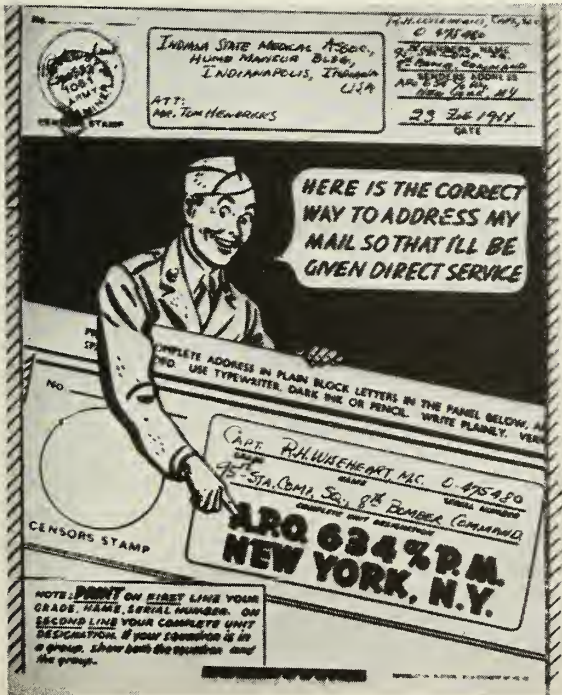
TAKE YOUR CHOICE!

We take the liberty of publishing the following abstract from an editorial which appeared in the Elkhart County Medical Society Bulletin, of January fifteenth:

"Only to be back home with the family, private practice; to get the sand out of my ears and heat out of my brain; or to feel the cooling relief of Indiana winds from tropical sweat, skeeter bites, humidity and mud; or get the chilblains thawed from feet and fingers; this is my dream at the end of the war! or Gosh! Give me a uniform and an active place where the wounded are, where my efforts seem to really count, away from obstetrics, wailing kids, neurotics, driveling droops and incurable seniles! Why, I'd even eat steaks to be in back of the man in back of the gun! And what can I tell my grandchildren? Stagnating at home! Monotonous sameness! No adventure!"

Again we wish to remind our members to notify this office regarding any failure to receive THE JOURNAL regularly. It is no small matter to keep a mailing list of several thousand names absolutely accurate, especially in view of the fact that we have more than one thousand physicians in military service and are making every effort to send THE JOURNAL to them. You will, therefore, bestow a favor not only upon yourself but upon THE JOURNAL office if you will notify us concerning your present address, if a recent move has been made.

Captain R. H. Wiseheart conceived a swell idea in the matter. Here it is:



Major Michael A. Rafferty, of Elkhart, reports that his work at present consists chiefly in reviewing the basic medical training of the enlisted personnel and in "polishing" up the laboratory technicians and pharmacy men. Major Rafferty is stationed at Fort Dix, New Jersey.

Tribute is paid to the infantryman by Captain Robert G. Husted, M.C., of Hammond, in the *Indianapolis Star* of March seventh. Captain Husted recently visited at his home in Hammond, while on a leave of absence under the Army's rotation plan, pending return to duty. So as to show a medical officer's high regard for the doughboys, we quote:

"One thing you learn at the front is to respect the infantryman one whale of a lot. The doughboys don't get what they deserve in the way of credit for the great job they are doing over there.

"The infantry has the toughest job in the entire Army. It is not only the tough fighting that it has to do—engaging the enemy hand to hand, but it is the living conditions under which the foot soldier has to exist. The infantry moves up to the front and stays there for as long as thirty days at a stretch, making its home in foxholes. Generally they have to lug up their supplies by hand, especially in such country as that through which they've been fighting in Italy.

"But the infantry goes right on fighting with surprisingly little grumbling. Just one tour at the front and you come back with high regard for those doughboys."

A message published in the *Lake County Bulletin*, for December, has so much merit that we feel it should be repeated in our magazine. This was written by Major Glenn E. Comstock, of Gary, who is serving with the Medical Corps in the European theatre of war.

"To our peace table this time must go no human being, but a composite man. He must have seen the death and desolation from air, land and sea; his nose must retain the stench of death, the rot of poverty, the nausea of burning flesh. He must still hear the cries of the dying, the maimed, the blinded, and the starving. He must still flinch from the din of the machine gun, and the cry of crashing bombs. His breath must be the souls of those who have died from the cold blue of the Arctic to the fire of the desert; his heart the deep love for those only who deserve sympathy and understanding.

"He must be steeled by the memory of those services who, without weapons, were murdered giving relief to the wounded and the dying, and who gave the last blessing to those beyond hope. He must have the 'guts' of our valiant units who burned in tanks, planes and submarines. He must recognize the objectives of permanent peace. This man, forged in the crucible of modern war, must dictate terms through the senses of those living and dead.

"He must be no rosey-visions idealist. He must exact revenge, when revenge is necessary. He must teach lessons that will endure forever. He must not fail us again!"

Dr. William Sholty, of Lafayette, has been promoted to a captain, according to word received here. Captain Sholty has just landed in England.

Captain Harold G. Petitjean, of Haubstadt, is now at the Station Hospital at Jefferson Barracks, Missouri.

Word has reached us to the effect that Captain Tyler J. Stroup, of Indianapolis, is now a major. He is serving somewhere in the Pacific Area.

Captain James V. Richart, of Terre Haute, has arrived safely in England, according to a cablegram received by Mrs. Richart. He had been stationed at Fort Hayes, Columbus, Ohio, for sixteen months.

Major Merle E. Whitlock, of Mishawaka, is now abroad and reported that the trip was rapid, fairly comfortable and uneventful. He did not reveal his whereabouts.

Italy is the camping ground of Captain J. W. Ward, of Mishawaka. He says that they moved into their hospital at night and before they were settled the Germans bombed it. Unfortunately, they had not had time to raise their Red Cross flags, so that was the first duty attended to in the morning. He also says that the Americans are hiring Italians now, and are paying them seventy-five cents a day, which they consider high after what they had been paid.

Colonel Guy Owsley, executive officer at Billings General Hospital, Fort Benjamin Harrison, received orders to report March first as commanding officer of an eight-hundred-bed hospital ship to return wounded American soldiers from the European war theatre. Prior to his assignment to Billings, Colonel Owsley practiced in Hartford City. Lieutenant Colonel Joseph E. Cannon, of Illinois, who has been in command of the ship, will take over as executive officer at Billings.

A letter received from Lieutenant-Commander E. Rogers Smith, of Indianapolis, who is with a United States Navy Mobile Hospital in the Pacific territory, indicates that he still retains his usual good sense of humor:

"I've been informed that I'm going to leave dear old — soon and be a bit closer to the source of my dear little fatigues and neurotics. To speak learnedly regarding them, you have to see them in the beginning. Rue Carter writes that 'the condition of my arteries and sphincters should keep me out of such places'; however, my skipper thinks otherwise."

Captain Ernie E. Norris, of Middlebury, is stationed at Fort Francis, E. Warren, Wyoming.

In a letter recently received from Captain Lowell G. Redding, of Huntington, we learn that he is now serving as assistant to the chief of the surgical staff at Eglin Field, Florida. He says that he has been doing all of the proctology and enjoys his work there. He reports that Captain Dale York, an Indiana University graduate of 1940, is flight surgeon of the group. He says, "I look forward to getting *THE JOURNAL* and am particularly interested in the Military News Notes, for they are practically the only way one has of maintaining contact with one's friends, especially his classmates of 1941."

We take the privilege of quoting the following excerpt from a letter received recently from Captain Alexander T. Ross, of Indianapolis:

"I enjoy *THE JOURNAL* a great deal. It has a touch of home to those of us overseas.

"For several months I was with the 298th General Hospital, affiliated with the University of Michigan, but have recently been transferred to this new neuropsychiatric general hospital. We're just getting started, so it will take a while before the machine is oiled. We are located in a beautiful part of England.

"Keep sending *THE JOURNAL*; that is why I want you to be sure to have the correct address."

The following V-Mail letter has been received from Major John L. Arbogast, now stationed in India, and will be of interest to his colleagues:

"The heading accounts for the fact that your letter of thanks for my little contribution to the December issue of *THE JOURNAL* reached me only on February 1, 1944. You were certainly most welcome. Actually that issue of *THE JOURNAL* has not yet caught up with me, and I eagerly await the opportunity of reading it.

"I have been especially fortunate in seeing a number of the Indiana medicos and wish now that I had gotten a number of up-to-date addresses for you. Saw Everett Mason and Herman Watson, formerly of Evansville; Gettelfinger, of Louisville; Neidballow, of Bristol, as well as a few more of the Indiana class of '36 who are now scattered about. I'll compare my list with *THE JOURNAL* when it arrives, and maybe can send in a few.

"Along with thousands of others, I suspect, let me thank you for the V-Mail letters we receive and chuckle over from time to time. We certainly appreciate our mail, and particularly those with a different slant, and in that respect they deserve the highest rating. Hope that some of our experiences over here are worth-while enough, and of enough value for work in the states later, so that we may offer further material to *THE JOURNAL*. The more I travel, the more I appreciate our Indiana group and realize that you and the others carrying it on deserve the highest praise."

An interesting letter was sent in by Captain Clarence V. Rozelle, of Anderson, who says he landed in North Africa after a dull and unhappy Christmas on the Atlantic. He says they soon moved up to Italy, and they all but had him in the front line there. He was all over Italy but is now back in North Africa, near where he originally landed. He has either been past or in 95 per cent of the headline cities of the entire Mediterranean campaign. "Our forces are really well set up over here and are doing an excellent job. Believe me, the weather in Italy is terrible; that is the coldest rain you ever saw. No heat except in the finest homes and a few buildings, and you freeze to the bone. Sleeping on marble floors is even considered a break at times. Your 'MedSoc' is fine, and certainly well received. Of prime interest is the Army addresses of our Hoosier confreres. Keep them coming often. We are often near each other and don't know it. Mail is the real hot-shot of the Army—particularly overseas. Regards to the gang."

Major S. W. Ellis, of Versailles, has written the following letter from Italy:

5 Jan. '44
Italy

"Dear Folks,

"It is 11:50 P.M., and I am sitting at my marble-topped table in my tile-floored office eating, of all things, hot buttered pop-corn. Sounds very swank, eh? Don't be fooled—all floors (that aren't dirt) in Italy are tile, and nearly all the tables have marble tops.

"Our 'home' is an Italian 'Ospedale Militare,' which is in buildings about one hundred fifty years old. The hospital proper is in one large rectangular building, four stories high with a central courtyard. Then there are all sorts of ward buildings and other utility buildings all over the place. Stairways and corridors, by the hundreds, are mostly outside affairs. We certainly get plenty of walking here. There are eighty-eight steps from the ground up to our ward, and each section of the ward is nearly as long as a city block. Covering my half of the hospital is like going over an eighty-acre farm. Contagion is over in a different building in one corner of the grounds. Four officers have quarters together; we have a large bedroom, bath and sitting room. This hospital is in the midst of sizeable grounds, which are thickly planted with orange trees. The fruit is nearly ripe but looks small and poor. We have promised not to touch it, but to leave it for the Italians. There is extensive evidence of bombing in all this area, most of which occurred during the period of German occupation.

"A flight of twenty-five bombers just went over—going back 'home,' I think. This place itself has never been touched. The Germans *do* respect the Red Cross on the roof. Many windows have been knocked out, most of them when an ammunition

train, which could not be got out, was blown up near here.

"We have Italian men keeping our quarters clean, shining our shoes, etc. They get fifty lire a day. There are some thirty to forty nuns who live here. They run the laundry, supervise the cleaning women and things of that sort.

"The spirit of our group is very gratifying. Everyone is working hard, willingly. They realize why they came, and the enlisted men consider themselves a fortunate lot when they see the ones from the front. The nurses are doing a wonderful job. Our C.O. keeps reminding us we are on duty twenty-four hours a day and seven days a week, but I doubt if we are working as hard as the doctors at home.

"We are gaining importance or becoming a great nuisance, I'm not sure which. We now have a new A.P.O. number, which is our very own. It should facilitate the handling of mail a great deal, and that is no small job in an establishment of this sort with a population of about twenty-five hundred. I am still chief censor, but finally managed to work out the details of the work so that it goes so smoothly that I'm no longer conscious of it. What a relief!

"As you can guess by the time of night, I'm O.D. tonight and I really enjoyed making my rounds. The moon is nearly full, but the wind is beginning to howl again and it is a bit above freezing. On my way back I came across two officers and their drivers who stopped in on their way back to the front to see if they could bum some hot coffee. They said that when they left this morning the wind was terrific and that they expected their tents to take off any time.

"New Years morning, early, there was a regular howler, too, that wrecked many of our window panes. That day we received 586 patients from a tent hospital that had been blown down. It was a riot.

"Our food has improved considerably recently. We get fresh meat nearly every day (hope it lasts) and butter frequently. Even had fresh eggs for breakfast New Years Day. We had a nice time during the holidays, for these parts at least. Christmas Eve my roommates had a birthday party for me, which was very fancy. They even brought out the Scotch which had been carried all the way from Colorado and guarded zealously through the vicissitudes of Africa. We rounded up soda and ice, even a couple of roasted chickens, etc. By New Years Eve we were down to Italian cognac again, which is the worst rot-gut of its kind, but which will drown one's cares if he doesn't mind a terrible hang-over the next day.

"Thanks again for the nice Christmas packages and for 'MedSoc,' which is really a swell job. They are quite interesting. We have another Indiana man in our group, Wendell Kelly, who practiced in Indianapolis.

"Cheerio" and hope you are all fine,"

SETH.

POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of March, 1919. This was omitted from the March issue.)

In the scientific section a symposium, consisting of three papers on the subject "The Thyroid Gland," appears. These papers had been read at the 1918 convention, at Indianapolis, by Drs. H. O. Pantzer, Goethe Link and H. K. Bonn—all of Indianapolis.

"Factors of Safety in Abdominal Hysterectomy" was the title of a paper by Donald Guthrie, of Sayre, Pennsylvania, and Dr. George S. Bond, Indianapolis, wrote on "The Soldier's Heart."

* * *

The editor occupied several pages in the editorial section with a discussion of "The Wassermann Test," a subject rather new in those days. There also was an editorial concerning the tooth brush, the editor deeming this household article, in most instances, a most insanitary affair. (We looked in vain for an advertisement of tooth brushes in this number of THE JOURNAL.) "American Autocracy" also came in for some discussion by the editor.

* * *

"Pay Your Dues" continued to be one of the slogans of the editor; seems as though dues payments in those days were about the same as now—many members being dilatory in that regard.

* * *

It seems that some of our county medical societies had cancelled their meetings during World War I, for which they were severely taken to task by the editor.

* * *

Dr. A. E. Guedel, Indianapolis, in service in France, had announced a new anesthetic, same being generally used in some of the French hospitals. It was a mixture of ether, ethyl chloride and chloroform, the formula having been devised by Dr. Guedel.

* * *

Now that the war was over, several Indiana physicians who had continued practice throughout the war, despite the fact that they were of retirement age, announced that their practices were for sale, together with their office equipment, and in many instances their homes as well.

* * *

The editor apparently had discovered that some physicians were "thirty to fifty years behind the times," and proceeded to talk about it in his inimitable manner. "We yet find doctors, supposedly intelligent, who try to treat enlarged tonsils and adenoid tissue in young children by local measures, who doubt the efficacy of diphtheria antitoxin, and who still cling to the fossilized idea that every patient with a pain in the back has 'kidney trouble.'"

The Federal Income Tax, due March 15, 1919, called for a payment of 6 per cent on the first \$4,000 of net income, beyond certain exemptions. (There has been quite some change in our tax laws these past twenty-five years!)

* * *

The editor was concerned about the fact that a few Indiana medical men showed definite signs of leaning toward Bolshevism. One physician had suggested that he would like to see an upheaval in this country that would result in a redistribution of wealth, to the end that all would be equal.

* * *

A movement was on foot in England to place all physicians under government control.

* * *

It was stated that the epidemic of influenza in 1918 cost one insurance company eighteen million dollars in claims.

* * *

Captain W. R. Davidson, Evansville, had "post carded" THE JOURNAL from Tours, France, where he was then stationed.

* * *

Dr. John N. Hurty, secretary of the Indiana State Board of Health, had been awarded a life membership in the American Pharmaceutical Association, making the third time he had received a fellowship in a national organization. The other two were the American Medical Association and the American Association for the Advancement of Science.

* * *

Lieutenant Arthur J. Whallon, Richmond, wrote that he was then in Bonn, Germany, with the Army of Occupation.

* * *

Traveling medical quacks were again abroad in the land, this time posing as "eminent eye doctors." Reports were made of some of their activities, in one of which they had duped an Indiana man to the extent of \$275 for a fake eye operation.

* * *

A bill had been introduced into the Indiana General Assembly, providing that all liquors confiscated in raids be turned over to hospitals within the state. (The bill did not pass!)

* * *

Indiana physicians reported as having received their discharge from service and returning to their homes for the resumption of practice, were: S. O. Leak, Indianapolis; C. C. Rozelle, Lagrange; B. J. Larkin, Indianapolis; John W. Sluss, E. D. Wa'es, Fletcher Hodges, C. D. Humes, and A. B. Graham—all of Indianapolis; J. S. Hickman, Pennville, and F. A. Tucker, Noblesville.

POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of April, 1919)

Three articles appeared in the scientific section: "The Clinical Significance of Blood in the Urine," by H. O. Mertz, then of LaPorte; "A Plea for Prenatal Care," by C. O. McCormick, of Indianapolis, and "Sarcoma of the Kidney in a Ten-Months-Old Child," by J. Y. Welborn, of Evansville.

* * *

In the editorial department the subject of "Sanatorium Treatment of Tuberculosis" is discussed. Also, there was an editorial on "Tobacco Prohibition," it having appeared that there was then a move on foot to ban the sale of tobacco within the country, a la the Volstead Act in regard to alcoholics.

* * *

Promotions of medical officers, which had been recommended before the Armistice and not yet carried out, were now being received by those concerned.

* * *

The operators of a health resort in Indiana had concocted a clever scheme—if it would work—that of appointing health examiners in the various sections of the state. However, the Senegambian was found in the fact that before the appointment was made it would be necessary for the appointee to purchase a five-hundred-dollar share of stock in the operating company.

* * *

Numerous cases of encephalitis lethargica had appeared in the state, believed to be the after-results of influenza.

* * *

Several locations for physicians returning from the war fields were reported.

* * *

The current session of the Indiana General Assembly had done right well for the health officials of the state, there being several sizeable appropriations made.

* * *

The editor made an additional comment on the anti-tobacco campaign, fearing that some modern edition of Carrie Nation might come up to him and knock a cigar out of his mouth.

The antivivisectionists and antivaccinationists were reported as being unusually busy at this time.

* * *

The nurses of Base Hospital No. 32, who saw much service in France, had landed at Hoboken.

* * *

Amendments to the Harrison Narcotic Act had made it mandatory for all physicians to re-register.

* * *

Wabash County had voted to establish a new county hospital.

* * *

Dr. Charles E. Savery, South Bend, had left for the East to spend a year in postgraduate work.

* * *

Lieutenant Colonel Carleton B. McCullough, Indianapolis, had been awarded the Croix de Guerre for bravery in action, by the French government.

* * *

The Irene Byron Tuberculosis Hospital, Fort Wayne, had been opened to the public.

* * *

The following Indiana physicians had received their discharge from the Medical Corps, and had returned to resume practice in this state: E. C. Kohlman, C. S. Auble, D. M. Reynolds, J. R. Newcomb—all of Indianapolis; D. L. Clutes, Laud; Delzie Lee, Alert; F. A. Tucker, Noblesville; J. B. Maple, then of Shelburn, and A. T. Fagaly, Lawrenceburg.

* * *

Franklin H. Martin, chairman of the General Medical Board, National Council of Defense, had written a letter of commendation to all members of the Council, complimenting them on the excellence of their work. Colonel Martin had made several visits to Indiana during the war and was quite familiar with the local setup, which was under the direction of J. Rilus Eastman.

* * *

An eastern drug concern advertised that neosalvarsan was ready for distribution.

* * *

A large oil refinery used a whole page in the advertising section, calling attention to the fact that "surgical wax relieves pain."

News Notes

Dr. T. R. Hayes, of Muncie, has been appointed a member of the Muncie Board of Health.

According to an announcement by Governor Henry F. Schricker, Dr. John H. Hare, superintendent of the Evansville State Hospital, has assumed temporary charge of the Madison State Hospital until a successor to the late Dr. James W. Milligan can be selected by the institution's board of trustees.

The United States Office of Civilian Defense announces the retirement of its chief medical officer, Dr. George Barr, and that the present assistant chief, Dr. W. Palmer Dearing, will succeed to the post.

Announcement has been made by Dr. R. J. Ballard, who recently completed his medical training at Indianapolis and who has been given a medical discharge from the United States Medical Corps, that he has opened a part-time office at Lebanon, also serving as plant physician at the Allison Engineering Company, at Indianapolis.

ELEVENTH COUNCILOR DISTRICT MEETING

The next meeting of the Eleventh Indiana Councilor District Medical Association will be held in Wabash, May 17, 1944. This will be an afternoon session only, with the following speakers: Dr. Don C. Hines, Eli Lilly Company, Indianapolis; Doctor Culp, Duemling Clinic, Fort Wayne; Dr. Russell Sage, Indiana University School of Medicine, Indianapolis.

The scientific program will follow a short business session. Doctors of the adjoining counties are especially invited.

ANNUAL MEETING OF AMERICAN PUBLIC HEALTH ASSOCIATION

The Executive Board of the American Public Health Association announces the Second Wartime Public Health Conference and the 73rd Annual Business Meeting in New York City, October 3, 4, and 5, 1944. Meetings of related organizations will take place on Monday, October 2. Headquarters will be the Hotel Pennsylvania.

The scientific program will be devoted to wartime emergency matters as they affect public health.

The Chairman of the Local Committee in Charge of Arrangements is New York City's Health Commissioner, Ernest L. Stebbins, M.D. The Chairman of the Program Committee is Reginald M. Atwater, M.D.

A cancer control clinic, sponsored jointly by the Madison County Medical Society and the Women's Field Army organization, has recently been opened at St. John's Hospital, in Anderson. There has been a good response, and it is thought that the clinic will be a definite help in the fight against cancer.

On March fifteenth, three Indianapolis physicians were honored by Army and Navy officials with the presentation of the "Civilian Service Award" for faithful service rendered at the Selective Service Induction Center. Those cited were: Drs. C. B. Bohner, Fletcher Hodges and William J. Dieter.

An all-day conference was held by the Indiana chapter of the American Social Hygiene Association, at the Claypool Hotel, on February twenty-fourth. Drs. Thurman B. Rice, A. F. Weyerbacher, Hugh Wilkerson and Herman G. Morgan, all of Indianapolis, took part in the round table discussions at this forum.

The election of Mrs. Eleanor Brown Merrill, executive director of the National Society for the Prevention of Blindness, as president of the National Health Council for 1944, was made public today. She is the first woman to be elected president since the founding of the Council in 1921. Mrs. Merrill succeeds Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene.

In celebration of the fiftieth anniversary of the Nurses Training School of the Welborn-Walker Hospital, Evansville, Dr. James Y. Welborn, president of the hospital, entertained one hundred and seventy guests, including the entire personnel of the institution, at a banquet in the Rose Room of the Hotel McCurdy. Nurses who have been graduated from the hospital over the entire fifty-year period, since 1894, were invited.

DIABETIC IDENTIFICATION TAGS

At the suggestion of the Medical Division of the United States Office of Civilian Defense, to prevent dangerous delay in diagnosis and to insure proper treatment during unconsciousness or coma, Eli Lilly and Company, Indianapolis 6, Indiana, in cooperation with the American Diabetes Association, will provide metallic identification tags to be worn by diabetic patients or carried in the pocket. The inscription reads "DIABETIC, If Ill Call PHYSICIAN." No advertising of any sort appears on the tags, which will be supplied to the medical profession on request.

DR. B. W. RHAMY CELEBRATES HIS SEVENTIETH BIRTHDAY

Dr. B. W. Rhamy, of Fort Wayne, celebrated his seventieth birthday on February eleventh, and a large group of friends met at a birthday banquet in his honor on the evening of February tenth at the Fort Wayne Country Club. The dinner was a gala occasion, and many of the fifty guests honored Doctor Rhamy by reminiscences and appreciations of his many years of service.

Doctor Rhamy graduated from The Fort Wayne Medical College in 1898, following which he worked for several years as assistant to Dr. G. W. McCaskey. During this time he spent six months as city bacteriologist, which stimulated an interest in laboratory medicine, and in 1905 he opened the Fort Wayne Medical Laboratory which he has conducted ever since. The opening of this laboratory was an historic event, for at that time the only other clinical pathology laboratory in the Middle West was the Columbus Laboratory in Chicago, and there were not more than two or three other laboratories of this type in the United States.

In the past thirty-nine years Doctor Rhamy has carried on his work with distinction and has done much to forward the cause of clinical pathology and medicine in general. His laboratory has served not only the City of Fort Wayne but a large area of eastern Indiana and western Ohio. In addition, he has published over seventy original scientific articles, among them some of outstanding value, including a method published in 1917 for the preservation of complement by the addition of sodium acetate; a triple stain for use in staining frozen sections; and a method for the cultivation of *P. tularensis*. Besides his scientific writing, he has for many years been interested in the field of genealogy and is widely known for his book "The Remy Family in America," as well as being co-author of the book "The Orvis Genealogy." Another hobby which has given him and his many friends great pleasure is his wild-flower garden, which is widely known as an outstanding collection of Indiana wild flowers.

During the first World War, Doctor Rhamy enlisted as a captain in the Medical Reserve Corps Laboratory, and following special training services at the Rockefeller Institute, the Army Medical School, and Fort Omaha, he joined Evacuation Hospital No. 8 at Dijon, France. He served with this hospital and later in the Army of Occupation in the Rhineland, returning home in the spring of 1919 to continue his work in the Fort Wayne Medical Laboratory.

During the evening many messages of congratulations were received and read to the guests. These came from all over the United States, from many nationally-known figures in laboratory medicine, as well as many laymen who wished to honor the Doctor on this occasion. Several beautiful gifts were presented to Doctor Rhamy, and the formal program was concluded by the presentation of an

illuminated scroll which was signed by all the guests. The text of the scroll follows:

"Please accept this scroll as a tribute to you, Captain B. W. Rhamy, M.C., World War I, 1918, in recognition of your contribution to Medical Science. Your skill, combined with a high sense of public duty, has endeared you to all gathered here tonight in Fort Wayne, Thursday, February 11, 1944, men from various professions and vocations who are happy to be in your circle of friends."

INDIANA UNIVERSITY NEWS NOTES

Medical and pre-medical students with Army status will be excluded from curtailment of the Army Specialized Training Program, as announced by the War Department, according to advices received by Dean W. D. Gatch, of the Indiana University School of Medicine, from Dean Willard C. Rappleye, chairman of the Executive Council of the Association of American Medical Colleges.

The exclusion of medical and pre-medical students will mean that more than three hundred medical students now enrolled in Indiana University, and approximately one hundred fifty pre-medical students scheduled to enter the university's medical school next May, will be permitted to continue their professional training. It also was taken to mean that approximately ninety pre-medical Army trainees will be sent to the university next month, in accordance with previously-made arrangements.

Dean Rappleye, in his telegram to Dean Gatch, said,

"Glad to report word just received from Washington that medical and pre-medical trainees excluded from cut in A.S.T.P. medical and pre-medical program to continue as heretofore."

Dean Gatch described the telegram as "reassuring," particularly in view of the unofficial reports that the Army, in order to obtain the 110,000 men needed for active field duty, might dip down into the medical student lists or call to active duty pre-medical students having enlisted Reserve Corps status.

The pre-medical students expected to be sent to the university, under a ruling of which Dean Rappleye advised will consist of three sections of thirty men each in Term Three of pre-medical training.

* * *

Establishment, by the Indiana University chapter of the Phi Delta Upsilon medical fraternity, of a scholarship plaque as a memorial to the late Dr. John F. Barnhill, of Indianapolis, who for many years was a member of the faculty of the University's School of Medicine, has been announced by Dean W. D. Gatch.

The Indiana University chapter, through its president, Stanley Hoffman of Terre Haute, junior medical student, also has offered to defray the expense of an annual address at the medical school by an outstanding anatomist. The address would

be given in connection with the inscription on the plaque of the name of the student achieving the highest scholarship in gross anatomy. The plaque will be placed in the medical building on the Bloomington campus.

* * *

Successful battle-front surgery, by use of a small kit of instruments supplemented by tinner's sheers, a bolt cutter and a bent teaspoon, is described by Major J. M. Palm, Army Medical Corps, (of Brazil, Indiana) in a letter released by the Indiana University School of Medicine. Major Palm, a graduate of the Indiana University School of Medicine, who served his internship at the Indiana University Medical Center, in Indianapolis, declaring the case to have been "an unusual one in which the gods who watch over surgeons and their patients were smiling on us," described a battle-front operation as follows:

"The patient had suffered a knife wound some eight inches in length in the abdomen. The knife blade had passed upward through the liver, diaphragm and into the lower lobe of the lung, and the liver was punctured just to the right of the gall bladder and again on the dome.

"We had a very small set of instruments, consisting of eight hemostats of various sizes and design, two tablespoon retractors, a large bolt cutter, a pair of tin shears, a collection of various scissors

—none of which would do very much cutting and were either too big or too little for the job.

"Under a pentothal sodium anesthetic we opened the abdomen by extending the incision made by the knife; the belly was full of blood and bile. We cleaned it out as best we could, not having any suction apparatus. We found the tear in the liver and repaired it with black silk, which was the only suture material we had, and it was taken from a sewing kit. The diaphragm was cut in an oblique manner for about two inches. This was repaired with black silk.

"We then closed the belly tight after first sprinkling it liberally with 'Gold Dust,' which is what we call sulfanilamide powder. We then made an incision over the eighth rib and removed about three inches of the rib; went through the pleura and pulled the lung down to where we could see the cut. There was considerable blood in the chest, which we removed with a teaspoon bent so that it would enter the opening. We sutured the lung, gave it a dose of 'Gold Dust' and got out.

"The patient showed signs of anoxia, so we rigged up a portable oxygen tank that had been taken from a wrecked bomber, and with a Lovelace mask gave him some oxygen; at the same time we gave him two flasks of plasma. We expected him to die, and for about forty-eight hours he almost lived up to our expectations, but on the tenth day we removed the stitches and today he is doing light duty. Why? I don't know."

IN RE SOCIAL SECURITY AMENDMENTS ACT OF 1943

The following is a copy of a communication prepared by the National Affairs Committee of the Hammond Chamber of Commerce and sent to the members of Congress:

"The National Affairs Committee of the Hammond Chamber of Commerce has given considerable thought and study to the above-captioned bill now pending before the Senate Finance Committee. It has unanimously determined that passage of the bill is inadvisable for the following reasons:

1. In our community, adequate medical care is available to all. The inadequacy of medical care is apparent only in rural areas which are economically sub-standard, and the bill would not necessarily correct that situation.
2. Experience has shown that adequate medical care can be obtained in sub-standard rural communities by voluntary privately-operated non-profit insurance associations, supplemented by state welfare organizations.
3. The control of medical, hospitalization, and similar benefits by one man, the Surgeon-General, is un-

American, and would tend to place such matters in politics.

4. The cost of the administration of the bill would increase taxes at a time when any further increase in tax is highly undesirable.
5. The entire program of social security should be one of subsistence without luxury. The bill would have a tendency to hinder initiative and thrift and encourage malingers.
6. There is absolutely no necessity for subsidies to institutions educating the medical profession. These institutions have done an excellent job without federal subsidies and have established high standards of medical education.
7. The bill, if it became a law, would create an economic upheaval in many fields in which private capital is now invested, to wit, insurance, hospitals, medical schools, research laboratories, and medicine. The institutions have been doing an excellent job for many years.

"In the light of these reasons we respectfully suggest that the action of the Committee should not be favorable to the bill."

Deaths

J. Delbert Foor, M.D., of Terre Haute, died February fourth at his home. Doctor Foor was seventy-two years of age. He was a graduate of the Medical College of Indiana, Indianapolis, in 1900.

* * *

Joel E. Saunders, M.D., of Grasscreek, died on January eleventh at the age of seventy-one. Doctor Saunders graduated from the Curtis Physio-Medical Institute, Marion, in 1895, and had practiced at Grasscreek for forty years.

* * *

Richard Dugdale, M.D., of South Bend, died at his home on February fifteenth after an illness of many years. He was sixty-nine years of age and retired from practice in 1932. He graduated from the Rush Medical College in 1892. Doctor Dugdale was a member of the St. Joseph County Medical Society, and had served as its president and later as secretary-treasurer for many years. He was also an honorary member of the Indiana State Medical Association and the American Medical Association.

* * *

Ralph S. Chappell, M.D., of Indianapolis, died March twelfth at the age of sixty-four. He graduated from the Medical College of Indiana, Indianapolis, in 1904, and had practiced medicine for the past forty years. Dr. Chappell limited his practice to otorhinolaryngology. He was a member of the American Academy of Ophthalmology and Otolaryngology and was assistant professor of Otolaryngology at the Indiana University School of Medicine. Dr. Chappell was also a member of the Marion County Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Isaac Ferree, M.D., Livonia, died March first at the age of eighty-nine. He graduated from the Kentucky School of Medicine, in Louisville, in 1880.

* * *

Paul C. Graham, M.D., of Columbus, died February twenty-fifth at the age of sixty-four. He was a graduate of the Medical College of Indiana, Indianapolis, in 1903, and limited his practice to otorhinolaryngology. Doctor Graham was a member of the Bartholomew County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Willis S. Pritchett, M.D., of Evansville, died February sixteenth at the age of eighty-three. He was a graduate of the Louisville Medical College in 1887.

* * *

Dudley H. Swan, M.D., Plainville, died February twentieth at a local hospital. He was seventy-five years of age. Doctor Swan was a graduate of the Hospital College of Medicine, Louisville, Kentucky, in 1900. He was a member of the Daviess-Martin County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Frank A. Tabor, M.D., Terre Haute, died March eighth at the Veterans Hospital, in Indianapolis, after an illness of several months. He was seventy-one years of age. Doctor Tabor was a past department commander of the American War Veterans, and was a member of the Vigo County Medical Society, the Indiana State Medical Association, and the American Medical Association.

DEATHS OF INDIANA PHYSICIANS IN 1943

(M) Member I. S. M. A.; (H) Honorary Member; (R) Retired

NAME	AGE	DATE	PLACE	Cause of Death on Death Certificate.
Hopkins, William B.	51	1- 1-43	Jeffersonville	Coronary occlusion.
Brockway, Charles J.	54	1- 8-43	Brookston	Cerebral hemorrhage. Hemiplegia.
Harpole, Charles B. (R).....	77	1-10-43	Evansville	Gastric hemorrhage. Gastric ulcer.
McKane, Harvey W. (R)	82	1-11-43	Columbus	Cerebral hemorrhage.
Stanley, James T. (R).....	81	1-27-43	North Vernon	Bronchopneumonia.
Keller, Amelia R.	72	1-28-43	Indianapolis	Coronary occlusion.
McWilliams, Oscar (M)	74	1-31-43	Anderson	Pneumonia.
Crawford, Edward F. W. (M)....	73	2- 4-43	LaPorte	Endocarditis. Arteriosclerosis.
Funkhouser, William H. (R).....	85	2- 7-43	Evansville	Chronic myocarditis. Arteriosclerosis.
Young, James B. (M).....	64	2- 8-43	Indianapolis	Myocarditis.
Porter, William J. (R).....	85	2- 8-43	Greensburg	Arteriosclerosis.
Edwards, Lewis H. (R).....	82	2-12-43	Monroeville	Chronic myocarditis. Pneumonia.
Best, S. Robert (M).....	70	2-13-43	Gary	Coronary occlusion.
Buckner, George W. (R).....	87	2-17-43	Evansville	Hypostatic pneumonia. Chronic myocarditis.

NAME	AGE	DATE	PLACE	Cause of Death on Death Certificate.
Conner, William H. (R).....	81	2-18-43	Fort Wayne	Influenza. Hypostatic pneumonia. Senility.
Bush, Charles R. (R).....	87	3- 4-43	Indianapolis	General arteriosclerosis.
Barnhill, John F.	78	3-10-43	Indianapolis	Myocardial failure. Chronic rheuma- toid arthritis. Cholecystectomy.
Lockett, Charles D.	81	3-13-43	English	Coronary arteriosclerosis.
Miller, Commander Harvey W.	59	3-19-43	Portland	Coronary thrombosis.
Reser, William M. (H).....	79	3-19-43	Lafayette	Pulmonary tuberculosis.
King, Edward F.	55	3-13-43	Anderson	Cerebral hemorrhage. Hypertension. Arteriosclerosis.
Rock, George	89	3-31-43	Auburn	Cancer of the stomach. General car- cinomatosis.
Garrigus, John O. (M).....	71	4- 2-43	Terre Haute	Paralysis agitans. Chronic myocar- dial degeneration.
Leslie, Gaylard M. (M).....	65	4- 6-43	Fort Wayne	Coronary occlusion.
Schafer, Donald W. (M).....	47	4-12-43	Fort Wayne	Coronary occlusion.
Henderson, Samuel T.	69	5- 3-43	Fort Wayne	Drowned.
Stults, Joseph E. (R).....	86	5- 6-43	Fort Wayne	Senility. Myocarditis.
Bailey, Walter S.	53	5- 8-43	Gary	Bronchopneumonia.
Steele, Howard F. (M).....	48	5-10-43	Claypool	Chronic myocarditis.
Carver, Walter F. (H).....	76	5-11-43	Albion	Empyema of gall bladder. Cholecys- titis.
Williams, Quincy L.	71	5-15-43	Folsomville	Cardiorenal disease.
Van Dament, Walter F. (M).....	56	5-19-43	Bloomington	Carcinoma of mediastinum.
Bowman, Ray A. (M).....	46	5-30-43	Elkhart	Brain tumor.
Laval, Edward J. (R)	73	6- 3-43	Evansville	Arteriosclerosis. Cardiovascular renal disease.
Thornburgh, Frank L. (R).....	86	6- 7-43	Middletown	Cardiovascular renal disease.
Hammond, Guido B. (M).....	67	6- 7-43	English	Postoperative gastroenterostomy.
Fitzpatrick, Bartholomew	84	6-15-43	Columbus	Pulmonary edema. Myocardial de- generation.
Tindall, William W. (M).....	66	6-18-43	Shelbyville	Cardiovascular renal disease. Cor- onary heart disease.
Laymon, Henry E.	75	6-19-43	Warren	Syphilitic meningoencephalitic psy- chosis.
Klingler, Martin E. (M).....	67	6-19-43	Garrett	Coronary thrombosis. Pulmonary atelectasis.
Hubbard, Henley H. (M).....	56	7- 4-43	Boswell	Cerebral hemorrhage. Hypertension.
Rowland, Calvin L. (M)	71	7- 8-43	West Point	Coronary occlusion. Hypertension.
Cottingham, Isham E. (H)	85	7- 9-43	Evansville	Myocardial insufficiency.
*Klee, Lieutenant Kurt B.	30	7-10-43	Indianapolis (Army)	Killed in action.
Brown, John W.	91	7-10-43	Huntington County	Apoplexy. Right side paralysis.
Hill, Frank E. (M)	81	7-15-43	Muncie	Cerebral hemorrhage. Arterioscler- osis.
Leuthart, Charles P. (M)	70	7-16-43	New Albany	Prostatism. Organic heart disease.
Gumbiner, Benjamin F. (M).....	47	7-17-43	Gary	Acute pulmonary edema. Acute my- ocardial failure.
Wilson, Arthur H.	65	8- 3-43	Indianapolis	Essential hyperplegia.
White, James M. (M).....	45	8- 5-43	Gary	Coronary occlusion.
Katterhenry, Edward H.	69	8- 8-43	Indianapolis	Uremia. Delirium exhaustion. Drug addiction.
Gugsell, Andrew F.	69	8-10-43	Ferdinand	Cerebral hemorrhage.
Brasher, Mills C.	78	8-13-43	Linden	General peritonitis. Acute colecys- titis. Intestinal obstruction. Chole- lithiasis.
Hatfield, James F.	70	8-13-43	Rossville	Sarcoma.
Merritt, Frank W. (M)	61	8-17-43	Gary	Coronary infarction.
Paynter, Horace M.	77	8-18-43	Salem	Cerebral hemorrhage. Hypertension. Diabetes mellitus.
Sellman, John P.	69	8-18-43	Washington	Uremia. Pyelitis. Cystitis.
Thralls, Charles Urban	65	8-23-43	Hymera	Hodgkin's disease.
Markley, Stephen C. (M).....	70	8-28-43	Richmond	Apoplexy.

NAME	AGE	DATE	PLACE	Cause of Death on Death Certificate.
Burkley, Howard W.	63	8-28-43	Seymour	Cerebral hemorrhage.
Squier, William C.	67	9- 1-43	Richmond	Myocarditis. Arteriosclerosis. Nephritis.
*Badertscher, Capt. Robert C. (M)	28	9- 6-43	Bloomington	Bomber crash.
McCracken, Henry M. (M)	70	9-11-43	Argos	Cerebral hemorrhage.
Stephens, Olen C. (M)	58	9-13-43	Evansville	Coronary thrombosis.
Paul, Joseph Oscar	62	9-30-43	New Castle	Auto accident.
Campbell, Daniel A.	72	10- 2-43	Boonville	Coronary occlusion.
Shaff, Dewitt C.	74	10- 7-43	Clinton	Angina pectoris.
Cox, H. Monford (M)	51	10-14-43	Indianapolis	Apoplexy.
Burkhardt, Arthur E. (M)	68	10-19-43	Tipton	Pulmonary edema. Coronary occlusion.
Arthur, Martin L. (M)	67	10-20-43	Patoka	Ruptured aortic aneurysm.
Eikenberry, B. Franklin (M)	73	10-23-43	Peru	Carcinoma of prostate and bladder.
Rees, Omar H. (H)	76	10-24-43	Knightstown	Coronary occlusion.
Lee, John Hays	87	10-27-43	Cannelton	Myocarditis. Empyema.
Kern, Frank W.	62	10-29-43	Seymour	Aortic stenosis.
Frost, Reuben F. (M)	87	11- 2-43	Huntington	Senility. Diabetes mellitus.
Stoner, Gerald H. (M)	70	11- 3-43	Valparaiso	Chronic nephritis. Hypertension.
Southwick, Archibald A. (M)	58	11- 4-43	Kendallville	Pneumonia. Chronic myocarditis.
Dean, Daniel Lee	78	11- 4-43	Hardinsburg	Cerebral hemorrhage. Chronic cardiovascular renal disease.
Murray, Donn P. (M)	73	11- 9-43	Dunkirk	Coronary occlusion.
Johnson, Leonidas B. (H)	85	11-15-43	Ireland	Lobar pneumonia.
McNeill, James H. (M)	63	11-14-43	Newcastle	Aortic regurgitation. Peptic ulcer.
Clevenger, William F. (M)	69	11-20-43	Indianapolis	Coronary occlusion.
Allin, John H. (R)	81	11-22-43	Fishers	Bronchopneumonia. Fracture right hip.
Triplett, Charles E.	81	11-25-43	Morocco	Carcinoma urinary bladder and prostate.
Sullivan, Arthur M. (M)	62	11-27-43	South Bend	Cerebral hemorrhage.
Schenk, William F.	77	11-28-43	New Corydon	Tumor in abdomen.
Jenkins, Wilbur O. (M)	82	12- 3-43	Indianapolis	Cerebral hemorrhage.
Bohannon, McKinley J. (M)	47	12-13-43	Terre Haute	Coronary occlusion.
Martin, Amos A.	79	12-14-43	Kokomo	Chronic myocarditis. Chronic rheumatism.
Willien, William F.	69	12-14-43	Indianapolis	Bronchopneumonia.
Stephenson, Ora L. (R)	78	12-17-43	Indianapolis	Chronic nephritis. Chronic myocarditis.
Wyatt, Andrew R. (M)	88	12-19-43	Fort Wayne	Pneumonia. Cardiovascular renal disease.
Bentle, Perry C. (M)	68	12-19-43	Greensburg	Coronary thrombosis. Coronary occlusion.
Craig, James A. (M)	72	12-25-43	Greenwood	Cerebral hemorrhage.
White, David	77	12-26-43	Tobinsport	Lobar pneumonia. Carcinoma of pancreas.

* Died in service.

THE RETURNING SOLDIER ENTERING THE PLANT

The photograph used on the cover page shows a soldier returning from active service in the South Pacific. Honorably discharged from the Marines, he now seeks employment on a war job at the AC Spark Plug Division. As he enters the gate, he wonders: "How will I be received? What are the plans for me?"

(The photograph was obtained through the courtesy of Clarence D. Selby, M.D., Medical Director, General Motors Corporation.)

Society Reports

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

February 20, 1944

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; N. K. Forster, M.D.; E. M. Shanklin, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Luncheon meeting: Permanent Study Committee on Health Insurance: W. H. Howard, M.D., Hammond, chairman; A. C. Yoder, M.D., Goshen; Clay Ball, Muncie; A. P. Hauss, M.D., New Albany, and C. P. Fox, M.D., Washington. Also Donald Trone, Indianapolis, insurance consultant.

Membership Report

Number of members Feb. 19, 1944	2,616
Number of members Feb. 19, 1943	2,536
Gain over last year	80
Number of members Dec. 31, 1943	3,344

Public Relations and Office Expansion

Report made upon progress of state association to coordinate and emphasize public relations.

Radio. Programs being broadcast in Indianapolis and arrangements being completed to start series known as "Your Health in War-Time" throughout the state.

Substantial increase in number of talks upon Wagner-Murray-Dingell Bill to county medical societies and laity under the direction of the Bureau of Publicity reported.

Upon the motion of Dr. Forster, the employment of an extra girl at the headquarters' office, through the Procurement and Assignment Service, was approved by the committee.

Additional space for THE JOURNAL office was approved.

The statements of receipts and expenditures for January for the association committees and THE JOURNAL were approved.

Annual Session, Indianapolis, October 3, 4 and 5, 1944

Meeting to be held with Dr. C. E. Cox, treasurer, and Mr. Karl Friedrichs, recorder of the Murat Temple, to make final arrangements for use of the Murat Temple.

Commercial exhibit. Floor plans to be mailed early in March.

Scientific Program Committee to meet March 5.

Word received from Air Surgeon's Office stating that that office will be glad to cooperate in the 1944 annual session of the state medical association, sim-

ilar to the cooperation received from the Ninth Naval District during last year's meeting.

Legislative, Legal and Social Security Matters

National

A. M. A. Legislative Bulletin No. 30 given to each member of the committee.

Report made that the Council on Medical Service and Public Relations of the American Medical Association is to establish a Washington office of some sort.

Report made upon National Conference on Medical Service meeting. Dr. Cleon A. Nafe was elected secretary of the conference for 1944.

Status of Wagner-Murray-Dingell Bill.

- a. Both bills remain in committee.
 - b. Morris Fishbein to speak at Terre Haute on March 23. All invited.
 - c. Results from "School for Speakers" have been satisfactory.
 - d. Letter received from laboring man against bill.
 - e. Letter received from regular Army medical officer stating that in the public mind often there is confusion in regard to the Surgeon General of the Army and the Surgeon General of the United States Public Health Service, and that many people believe that the provisions of the Wagner-Murray-Dingell Bill would be administered by the Surgeon General of the Army. The committee suggested that it might be well for THE JOURNAL to point out this confusion that may exist in the public mind.
- Rehabilitation of returned military men is the big coming problem. The recent Industrial Health Congress at Chicago stressed this problem.

New Medical Organizations

Material upon the Western States Public Health League and the Association of American Physicians and Surgeons (of Lake County) brought to the attention of the committee. The committee discussed these organizations but took no action either of approval or disapproval.

Organization Matters

Official notice received from Secretary of the Twelfth District Medical Society that Dr. A. J. Sparks had been elected councilor for the Twelfth District.

Medical Economics

Copy of letter from A. M. A. in regard to Fourth War Loan sent to county medical societies.

Resolutions of the Noble County Medical Society against the Wagner-Murray-Dingell Bill and upon the Fourth War Loan brought to the attention of the Executive Committee.

The committee approved retention of membership in the Indiana State Conference on Social Work.

War Medicine

The committee expressed its regret that Dr. Charles R. Bird, chairman of Procurement and Assignment Service for Indiana and the War Participation Committee, is ill. Dr. John R. Newcomb, vice-chairman, is acting in his place. The committee suggested that flowers be sent to Dr. Bird.

Indiana communities in need of physicians. A list of communities in need of physicians as of December 1, 1943, as reported by the State Procurement and Assignment chairman, follows:

<i>City</i>	<i>County</i>
Boswell	Benton
Claypool	Kosciusko
French Lick	Orange
Lawrenceburg	Dearborn
Medora	Jackson
Middletown	Henry
New Harmony	Posey

State Board of Health

The typhoid epidemic and complaint from the Miami County Medical Society brought to the attention of the committee.

Child and maternal care program. Letter from the Greene County Medical Society, stating that the physicians of that county would discontinue the program, brought to the attention of the committee. Other letters upon this subject brought to the attention of the committee.

Socialized Medicine

Two items were discussed by the committee under this head—

"Work Opportunities," a bulletin from The Los Angeles County Civil Service Commission, telling of openings in full-time salaried positions for physicians. Interesting item was the fact that this specified in each case "48-hour week."

The Medical Science Center of Wayne University, Detroit, announcement told of a fifty-million-dollar civic project to be built around Wayne University's College of Medicine.

These two items were from far different sources but perhaps indicate the trend toward the socialization of medicine.

Group Hospitalization and Voluntary Health Insurance

Dr. Nafe and Dr. McCaskey reported that the committee of the Indiana Hospital Association,

which is considering the establishment of a mutual insurance company that will comply with the requirements of the Blue Cross Plan, is to meet February 26. Mr. Ken F. Helsby, director of Surgical Care, Inc., of Kansas City, is to be present. Representatives of the Indiana State Medical Association are to sit in on these meetings with the hospital association and are to keep the Executive Committee informed as to developments.

Resolutions passed by pathologists and radiologists against the inclusion of their services as hospital services in any pre-payment plan brought to the attention of the committee.

Report of Permanent Study Committee on Health Insurance presented by Dr. Howard, chairman of the committee. The Health Insurance Committee met with the Executive Committee and discussed numerous phases and plans. Among the service plans discussed were the Michigan State Medical Society Medical Service Plan, the Kansas City Plan, and the Indemnity Plan of the Connecticut State Medical Society. Dr. Howard stated that the first thing to decide is whether a pre-payment service plan or a pre-payment indemnity plan should be recommended to the House of Delegates. Recommendations of the House of Delegates last September in regard to the duty of the Health Insurance Committee follow:

"Your reference committee recognizes the need for a health insurance plan that will not interfere with the delivery of the best medical service, that will provide for the relationship of the insurer directly with the patient and not with the physician—a cash-indemnity plan that will not interfere with the patient-physician relationship.

"Your reference committee, therefore, recommends (a) that the Permanent Study Committee on Health Insurance be directed to draft the provisions of the best available plan; (b) that such plan be presented to the Council of the Indiana State Medical Association for its consideration and approval; and (c) that such plan be presented to the Association for its endorsement and presentation to the public."

The question was then discussed and it was decided that the Permanent Study Committee on Health Insurance has the authority to make studies of all plans, both service and indemnity, and to recommend either a service or an indemnity plan or a combination of the two.

Suggestion made that representatives of the Indiana committee meet with the representatives of the Wisconsin State Medical Society and discuss possibilities and plans, as the Wisconsin Society is in the same position as Indiana in studying these plans in order to recommend one for adoption in that state.

State Board of Medical Registration and Examination and Cult Practice

Status of students graduated from medical school who have their degrees but have not yet had the opportunity to take the State Board examinations discussed by the committee. These students may work under a physician until they have the opportunity to take the State Board examinations, but they cannot do individual practice.

Medical Relief

Report by Dr. Alfred Ellison, member of the State Advisory Committee on Medical Aid, in regard to medical relief problems, which was made before the Council of the state association at its mid-winter meeting, brought to the attention of the committee.

Drs. Ellison, Black and Boggs appointed to serve on State Advisory Committee on Medical Aid to the State Department of Public Welfare.

Future Medical Meetings

Tentative program for the second annual Industrial Health Conference of the Indiana State Medical Association brought to the attention of the committee. This meeting is to be held Wednesday and Thursday, April 19 and 20, 1944.

A. M. A. meeting Chicago, June 12 to 16, 1944.

The Journal

Additional space for THE JOURNAL office, at 1017 Hume Mansur Building, was approved by the committee upon the motion of Dr. Forster.

Medical Defense

Report by Dr. Nafe in regard to group malpractice coverage to be made at next meeting of the committee. Dr. Nafe reported that he had had conferences with several insurance groups and that he hoped to have a preliminary report with a suggestion as to action for the next meeting of the Executive Committee.

There being no further business, the meeting was adjourned.

Plan to attend the
**INDUSTRIAL HEALTH
CONFERENCE**

April 19 and 20

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

January 14, 1944.

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D.; Mrs. Lotys Stewart, and T. A. Hendricks, executive secretary.

The following articles have been released to the newspapers:

Dec. 10—"Doctors in the War."

Dec. 12—"Health on Your Christmas Shopping List."

Dec. 22—"Take Keer o' Yerself."

Jan. 1—"Indiana Doctors in 1943."

Jan. 10—"Tuberculin Testing in Schools."

Jan. 12—"Meningitis."

Jan. 12—"Secretaries' Conference—School for Speakers."

A second release on the Secretaries' Conference was approved for publication on January 17.

Arrangements completed for the "School for Speakers" program that is to be held in connection with the Secretaries' Conference on January 23, in Indianapolis.

Reports on medical meetings:

Dec. 17—Seventh District Medical Society, Martinsville. "Wagner-Murray-Dingell Bill." (45 present.)

Dec. 17—Cass County Medical Society, Logansport. "Industrial Health."

Dec. 17—Indiana Health Council, Indianapolis. Discussion of Wagner-Murray-Dingell Bill. (20 present.)

Jan. 4—Annual meeting of the Indianapolis Medical Society, Indianapolis. "Wagner-Murray-Dingell Bill." (150 present.)

Jan. 9—Midwinter Council meeting, Indianapolis. "Radio Program of State Medical Association." (28 present.)

Dec. 8—Thirteenth District Medical Society, South Bend. "The Treatment of Infantile Paralysis." (400 present.)

Future medical meetings:

Jan. 23—Secretaries' Conference, Indianapolis.

Feb. 13—National Conference on Medical Service, Chicago.

Requests for speakers:

Jan. 17—Rotary Club, Columbus. Speaker obtained to talk on Wagner-Murray-Dingell Bill.

Jan. 21—Cass County Medical Society, Logansport. Speaker obtained to talk on Wagner-Murray-Dingell Bill.

Jan. 30—Secretaries' Conference, Michigan State Medical Society, Detroit.

Editorials that have appeared in "The Indiana Farmers Guide" in regard to socialized medicine brought to the attention of the Bureau.

Half-page advertisement in the November 24 "Lafayette Journal and Courier" on the Wagner-

Murray-Dingell Bill brought to the attention of the Bureau.

The Shelby County resolution on the Wagner-Murray-Dingell Bill brought to the attention of the Bureau.

BUREAU OF PUBLICITY

February 4, 1944.

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D., by proxy, and T. A. Hendricks, executive secretary.

A second article on the Secretaries' Conference was released for publication on January 17.

The release, "Heart Disease" was approved for publication on February 14, 1944.

Reports on medical meetings:

Jan. 17—Rotary Club, Columbus. "Wagner-Murray-Dingell Bill." (100 present.)

Jan. 18—Woman's Auxiliary to the Howard County Medical Society, Kokomo. "Postwar Medical Planning and Wagner-Murray-Dingell Bill." (400 present.)

Jan. 21—Cass County Medical Society, Logansport. "Wagner-Murray-Dingell Bill."

Jan. 23—Secretaries' Conference, Indianapolis.

Jan. 30—Secretaries' Conference, Michigan State Medical Society, Detroit. "What Should Be Told the Public in Regard to the Wagner-Murray-Dingell Bill." (208 present.)

Future medical meetings.

Feb. 8—The Forty-Niners, Inc., Indianapolis. "Wagner-Murray-Dingell Bill." Speaker to be obtained.

Feb. 9—Hancock County Medical Society, Greenfield. "Wagner-Murray-Dingell Bill."

Feb. 12—Medical and Hospital Service Plans, Chicago.

Feb. 13—National Conference on Medical Service, Chicago.

Feb. 14 and 15—Council on Medical Education and Hospitals, Chicago.

Mar. 28—Goshen Business and Professional Women's Club, Goshen. Speaker obtained to talk on "Wagner-Murray-Dingell Bill."

Apr. 12—Woman's Auxiliary to the Floyd County Medical Society, New Albany. "Wagner-Murray-Dingell Bill."

Radio schedule for January and February:

Monday —WTRC, Elkhart, 8:15 p.m.

WFBM, Indianapolis, 3:45 p.m.

Tuesday —WKMO, Kokomo, 6:30 p.m.

Wednesday—WOWO, Fort Wayne, 4:15 p.m.

Thursday —WBOW, Terre Haute, 12:15 p.m.

Friday —WSBT, South Bend, 1:45 p.m.

Special program during January—January 23, WIBC, Secretaries' Conference.

Letters from the Public Relations Council and the Board of Trustees of the American Medical Association in regard to the speakers' kits on the Wagner-Murray-Dingell Bill brought to the attention of the Bureau. The general opinion is that these are most valuable and worth while.

The Terre Haute advertisement of January 16 on the Wagner-Murray-Dingell Bill was brought to the attention of the Bureau.

BUREAU OF PUBLICITY

February 25, 1944.

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D., by proxy, and T. A. Hendricks, executive secretary.

Two articles, one on "Measles" and the other on "Whooping Cough," were prepared for publication in the newspapers. These articles are to be sent to some pediatricians for their suggestions and approval.

Reports on medical meetings:

Feb. 8—The Forty-Niners, Inc., Indianapolis. "Wagner-Murray-Dingell Bill." (25 present.)

Feb. 12—Medical and Hospital Service Plans, Chicago.

Feb. 13—National Conference on Medical Service, Chicago.

Feb. 14 and 15—Council on Medical Education and Hospitals, Chicago.

Feb. 15 and 16—Industrial Health Conference, Chicago.

Feb. 18—Hancock County Medical Society, Greenfield. "Wagner-Murray-Dingell Bill and Present Status of Medical Organization." (30 present.)

Feb. 18—Cass County Medical Society, Logansport. "Surgical Treatment of Varicose Veins." (15 present.)

Future medical meetings:

Feb. 29—Indianapolis Council on CIO. "Wagner-Murray-Dingell Bill."

Mar. 15—Professional Men's Forum, Indianapolis. "Wagner-Murray-Dingell Bill."

Mar. 23—Vigo County Medical Society, Terre Haute.

Mar. 28—Goshen Business and Professional Women's Club, Goshen. Physician from South Bend obtained to speak on "Wagner-Murray-Dingell Bill."

Mar. 29—Hamilton County Medical Society, Noblesville. Speaker obtained to talk at open meeting on "Wagner-Murray-Dingell Bill."

Apr. 12—Woman's Auxiliary to the Floyd County Medical Society, New Albany. Speaker obtained to talk on "Wagner-Murray-Dingell Bill."

The Bureau approved the payment of the bill for \$54.45 for printing of the Woman's Auxiliary program kits and suggested that next year this expense might be eliminated by having reports printed in *THE JOURNAL* and calling the attention of the various Auxiliary officers to *THE JOURNAL* containing the annual reports.

The budget allowed the Bureau of Publicity for 1944 is \$1,735.07.

Letter received from the Woman's Auxiliary suggesting that the Auxiliary have a House of Delegates meeting in the spring in order to coordinate their work with the national Auxiliary. The Bureau felt that this matter should be considered further before approval is given.

COUNTY SOCIETIES

COUNTY MEDICAL SOCIETY OFFICERS

BARTHOLOMEW COUNTY MEDICAL SOCIETY:

President, W. S. Fisher, Columbus.
Vice-president, H. H. Kamman, Columbus.
Secretary-treasurer, Marvin R. Davis, Columbus.

JOHNSON COUNTY MEDICAL SOCIETY:

President, Harry E. Murphy, Franklin.
Vice-president, R. C. Wilson, Franklin.
Secretary-treasurer, J. H. Machledt, Whiteland.

LOCAL SOCIETY REPORTS

Adams County Medical Society members held a meeting at the Adams County Memorial Hospital, in Decatur, on March first. The eight members present held a general discussion and appointed a committee to prepare articles for newspapers in regard to the Wagner-Murray-Dingell Bill.

* * *

Bartholomew County Medical Society members met at the office of Dr. Dorothy Teal, Columbus, on February twenty-third. This was a business meeting and the society voted to join the Association of Physicians and Surgeons, Incorporated, as a society. Seven members attended the meeting.

* * *

Benton County Medical Society members held a meeting at Fowler, on February fourteenth. Plans were made by township trustees and members of the society for a county-wide immunization program for typhoid fever.

Clay County Medical Society members held a meeting at Dr. C. C. Sourwine's home, at Brazil, on February fifteenth. Dr. Charles N. Combs, of Terre Haute, spoke on "Hospital and Medical Insurance." Six members were present at the meeting.

* * *

Delaware-Blackford County Medical Society members met at Hotel Roberts, Muncie, on February fifteenth. The program was devoted to a general discussion of business matters, including the Wagner-Murray-Dingell Bill.

* * *

Fort Wayne County Medical Society members met at the Chamber of Commerce Building, on February fifteenth. The speakers of the evening were Dr. E. T. Franklin, superintendent of the Methodist Hospital, Fort Wayne; Mr. Alva J. McAndless, president of the Lincoln National Life Insurance Company, and Mr. Guy W. Spring, assistant director of the Hospital Care Corporation, Cincinnati.

* * *

Indianapolis (Marion County) Medical Society members held a meeting at the Indianapolis Athletic Club on March seventh. The following case reports were presented: "Brachial Plexus Block Anesthesia in Injuries of the Upper Extremities," by Dr. William Marshall; "Psychoneurosis in General Practice," by Dr. O. S. Jaquith; "Pulmonary Infarction," by Dr. Harry Kerr; "Thrombocytopenic Purpura," by Dr. N. Cort Davidson; and "Unusual Complication of Pregnancy," by Dr. Roy V. Myers.

On March fourteenth Major C. S. Wilson, chief of Medical Service, Billings General Hospital, was in charge of a round table discussion of "Arthritis," "Peptic Ulcer," and "Hematuria."

The speaker for the meeting on March twenty-first was Dr. Charles Doan, professor of Medicine, Ohio State University. Doctor Doan presented a paper on "Differential Diagnosis and Therapy of Blood Dyscrasias."

At a meeting held March twenty-eighth, Mr. A. L. Young, vice-president and general manager of the Eli Lilly International Corporation, spoke on "Conditions in the Orient and What the Future May Hold," and Dr. Edgar F. Kiser presented "Medicine as Depicted in the Classic Arts."

* * *

LaPorte County Medical Society members were entertained at a buffet dinner at the Rumely Hotel, LaPorte, on February seventeenth. The speaker of the evening was Dr. R. N. Harger, of Indianapolis, who spoke on "Domestic and Industrial Poisonings." Twenty-six members were present.

* * *

Miami County Medical Society members met at the Dukes-Miami County Memorial Hospital, Peru, on February twenty-fifth. The five members present discussed the proposal of the State Board of Health to appoint a full-time health inspector for Miami County.

(Continued on page xxiii)

(Continued from page 224)

Pike County Medical Society members held a dinner meeting February eighth, at the Christian Church in Winslow. Following the election of officers, Mrs. I. O. Gladdish spoke on her life as an Army officer's wife in the Philippine Islands. Guests of the society were the doctors' wives and the public health nurses.

* * *

St. Joseph County Medical Society members held a meeting at the Indiana Club on February eighth. Dr. Paul E. Haley, of South Bend, presented a paper on "Urgent Surgery." Thirty-nine members were present.

Another meeting was held on February twenty-third. The guest speaker for this meeting was Dr. Louis Katz, of the Michael Reese Hospital, Chicago, who spoke on "The Principles in the Diagnosis and Treatment of Peripheral Vascular Diseases." Forty-two members and twenty-seven visitors attended the meeting.

On March seventh the members were entertained by Dr. Holland Thompson, Indiana State Board of Health, who spoke on "The Relation of Tuberculosis Control to Private Practice in Public Health." Twenty-six members and six visitors were in attendance.

HOWARD COUNTY MEDICAL SOCIETY RESOLUTION

WHEREAS, in making this declaration of purpose, the physicians of Howard County reaffirm their faith in the traditional relationship which always has existed between the sick individual and the physician of his choice; and

WHEREAS, we of the medical profession give public assurance that, as always in the past, we expect to give to those who desire our services the best medical care of which we are capable—the doctors of this county will continue to care for the health needs of all the people, under all circumstances;

THEREFORE BE IT RESOLVED, That we are willing to cooperate in any feasible, voluntary plan for distributing the cost involved.

BE IT FURTHER RESOLVED, That we are, however, unalterably opposed to and will not participate in any plan that is against the public welfare by being destructive to the best traditions of the profession or interferes seriously with the freedom of action and initiative that has in such large measure made possible the present high standards and accomplishments of the art and science of medicine.

BE IT FURTHER RESOLVED, That copies of this resolution be sent to other county medical societies for their consideration and action.

LEGISLATIVE COMMITTEE,
HOWARD COUNTY MEDICAL SOCIETY,
R. P. Schuler, M.D., *Chairman*
H. M. Rhorer, M.D.
P. W. Ferry, M.D.

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(In affiliation with COOK COUNTY HOSPITAL)
Incorporated not for profit

ANNOUNCES CONTINUOUS COURSES

SURGERY—Two Weeks Intensive Course in Surgical Technique starting April 3, 17, and every two weeks throughout the year. One Week Course in Colon and Rectal Surgery starts April 17 and June 5.

MEDICINE—Two Weeks Intensive Course Internal Medicine starts June 19. Two Weeks Course Gastro-Enterology starts June 5.

GYNECOLOGY—Two Weeks Intensive Course starting June 12. One Week Personal Course Vaginal Approach to Pelvic Surgery starts April 17.

OBSTETRICS—Two Weeks Intensive Course starts April 17 and June 26.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

GASTROSCOPY—Personal Course starts April 3, June 19, and October 16.

OTOLARYNGOLOGY—Two Weeks Intensive Course starts April 3 and October 2.

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GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

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WOMAN'S AUXILIARY
to the
Indiana State Medical Association

President—Mrs. James Baxter, Jr., New Albany
President-elect—Mrs. F. M. Gastineau, Indianapolis
Corresponding Secretary—Mrs. John Habermel, New Albany
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis

ALLEN COUNTY

Approximately fifty members attended the desert meeting of the Allen County Medical Auxiliary, for which Mrs. Ernest R. Carlo was hostess on February first. Mrs. George Turner reviewed "Burma Surgeon." Mrs. E. M. Van Buskirk was general chairman of the evening.

VANDERBURGH COUNTY

Mrs. Fletcher Stewart, secretary to the Vanderburgh County Medical Auxiliary, recently sent your publicity chairman a resumé of their activities. We hope that some of these ideas may be of use to other auxiliaries.

The Executive Board meeting was held on August first. It was suggested that there be five meetings of the auxiliary during the year, and at a subsequent meeting it was voted that the second Wednesday in the month be chosen. Due to the uncertainty of the times, no planned program was attempted. Instead, they decided to plan programs two meetings ahead. In order to induce interest and attendance in the auxiliary, a suggestion was made that five dollars in war stamps be given at each meeting as a contest prize.

On October sixth a luncheon was held at the Vendome Hotel, with thirty-six members in attendance. Dr. Fletcher Stewart, officer in charge of the United States Marine Hospital, spoke on the scope of the United States Public Health Service. Important phases of the Wagner-Murray-Dingell Bill were presented by Mrs. W. F. Healey, of the Legislative Committee. A motion was made and carried that the auxiliary subscribe to two copies of the *National Auxiliary Magazine*, to be circulated among the members and discussed at each meeting.

On November eighteenth, Mrs. C. W. Cullnane, public relations chairman, reported that the Pediatrics Committee had visited the Hillcrest Home for Children, and that it recommended the purchase of fluorescent lights for the boys' and girls' study halls. The motion was made and carried. The auxiliary accepted a request from the Tuberculosis Association that they sell Christmas Seals for one day, December sixth, in banks, stores and other public places. Sixty-five dollars were collected, a record second to the highest made by an Evansville organization.

Mr. Lowell Turner, superintendent of the Hillcrest Home for Children, and Mr. Maurice Hunt, executive secretary of the Council of Social Agencies, were guest speakers at the November eighteenth meeting. Following their discussion of juvenile problems, a motion was made and carried that a committee be appointed to draw up a resolution expressing the auxiliary's interest in the project undertaken by Mr. James Newcom to set up recreation centers for adolescents.

ABSTRACT: METRIC SYSTEM ADOPTED

"Attention is called to the announcement elsewhere in this issue that future editions of New and Nonofficial Remedies, Useful Drugs, the Epitome of the U. S. Pharmacopeia and National Formulary and Interns' Manual (with the consent of the Council on Medical Education and Hospitals [of the American Medical Association]) as well as other Council publications, will give quantities and dosages exclusively in the metric system," *The Journal* of the Association says in its December 4 issue. "This step is in harmony with the growing and current practice of prescribing vitamins, hormones and sulfonamide preparations. The Council's concise historical presentation of the units of measure formerly in common use emphasizes the value of adopting a uniform method of presenting quantities and dosages. While daily living may have been governed for many years by grains and barley corns, the kingly nose and regal thumb, and the combined length of the left feet of 'sixteen men who lined up heel to toe as they left church on a Sunday morning,' workers in the exact sciences appreciate the value of the simplicity, convenience and precision of the metric system. Universal adoption of this system will be a manifestation of rationality and of interprofessional and international cooperation of great practical utility."

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report, February, 1944

DISEASES	Feb. 1944	Jan. 1944	Dec. 1943	Feb. 1943	Feb. 1942
Pulmonary Tuberculosis	161	250	300	208	66
Other Forms, Tuberculosis.....	2	3	37	103	16
Chickenpox	629	387	222	422	439
Measles	1135	1085	460	1161	265
Scarlet Fever	620	451	239	451	571
Smallpox	10	2	3	29	1
Typhoid Fever	174	47	3	2	6
Whooping Cough	105	81	92	168	182
Diphtheria	37	61	32	18	29
Influenza	73	573	2431	99	136
Pneumonia	46	80	42	253	79
Mumps	261	120	74	557	68
Malaria	4	37	1	0	1
Poliomyelitis	2	6	0	1	2
Cerebrospinal Meningitis	39	65	25	21	3
Nonepidemic Meningitis	1	1	1	0	0
Impetigo	3	3	0	0	0
Tularemia	1	5	5	2	0
Septic Sore Throat	3	0	0	0	1
Food Poisoning	2	6	0	0	0
Undulant Fever	9	2	3	0	2
Rubella	10	65	120	1502	9
Ascending Myelitis	1	0	0	0	0
Infectious Jaundice	1	1	0	0	0

Books

BOOKS RECEIVED

SULFONAMIDE THERAPY IN MEDICAL PRACTICE. By Frederick C. Smith, M.D., Editor of Philadelphia Medicine and The Medical World. 368 pages with numerous illustrations. Cloth. Price \$5.00. F. A. Davis Company, Philadelphia, 1944.

CLINICAL LECTURES ON THE GALLBLADDER AND BILE DUCTS. By Samuel Weiss, M.D., clinical professor of Gastroenterology, New York Polyclinic Medical School and Hospital. 504 pages with 125 illustrations. Cloth. Price \$5.50. The Year Book Publishers, Incorporated, Chicago, 1944.

PSYCHOSOMATIC MEDICINE. The Clinical Application of Psychopathology to General Medical Problems. By Edward Weiss, M.D., professor of Clinical Medicine, Temple University Medical School, Philadelphia; and O. Spurgeon English, M.D., professor of Psychiatry, Temple University Medical School, Philadelphia. 687 pages. Cloth. Price: \$8.00. W. B. Saunders Company, Philadelphia, 1943.

REVIEWED

MICROBES WHICH HELP OR DESTROY US. By Paul W. Allen, Ph.D., Professor of Bacteriology and Head of the Department, University of Tennessee; D. Frank Holtman, Ph.D., Associate Professor of Bacteriology, University of Tennessee; and Louise Allen McBee, M.S., Formerly Assistant in Bacteriology, University of Tennessee. 540 pages with 102 text illustrations and 13 color plates. Cloth. Price \$3.50. The C. V. Mosby Company, St. Louis, 1941.

The authors state that this book was written to satisfy the need of the layman for information about microbiology, and they have succeeded quite well in their purpose. Although practically all of the book is devoted to bacteriology, malaria and amoebic dysentery are discussed, and the fact that fungi may cause disease is mentioned. The public health aspect of disease is emphasized, so the reader should have a more intelligent idea of his responsibility in the community.

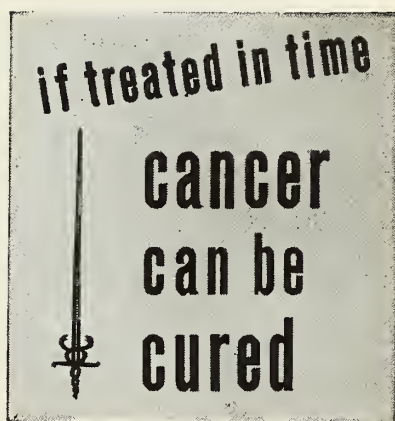
The chapters on water, milk, food preservation, and food poisoning should be especially interesting to the layman. The discussion on staphylococcal food poisoning was disappointing because the means of preventing it, which should be emphasized, were not mentioned.

The order of some of the chapters seems illogical; for example it would seem better to have the chapters on Drinking Water and Sewage Disposal together, because of their relationship, and the chapters on viruses grouped together.

The reader will find considerable history of bacteriology and medicine in the book, which adds greatly to its interest. The book is printed on good paper and contains a number of excellent illustrations. Altogether it has much merit.

EDITH HAYNES, PH.D.

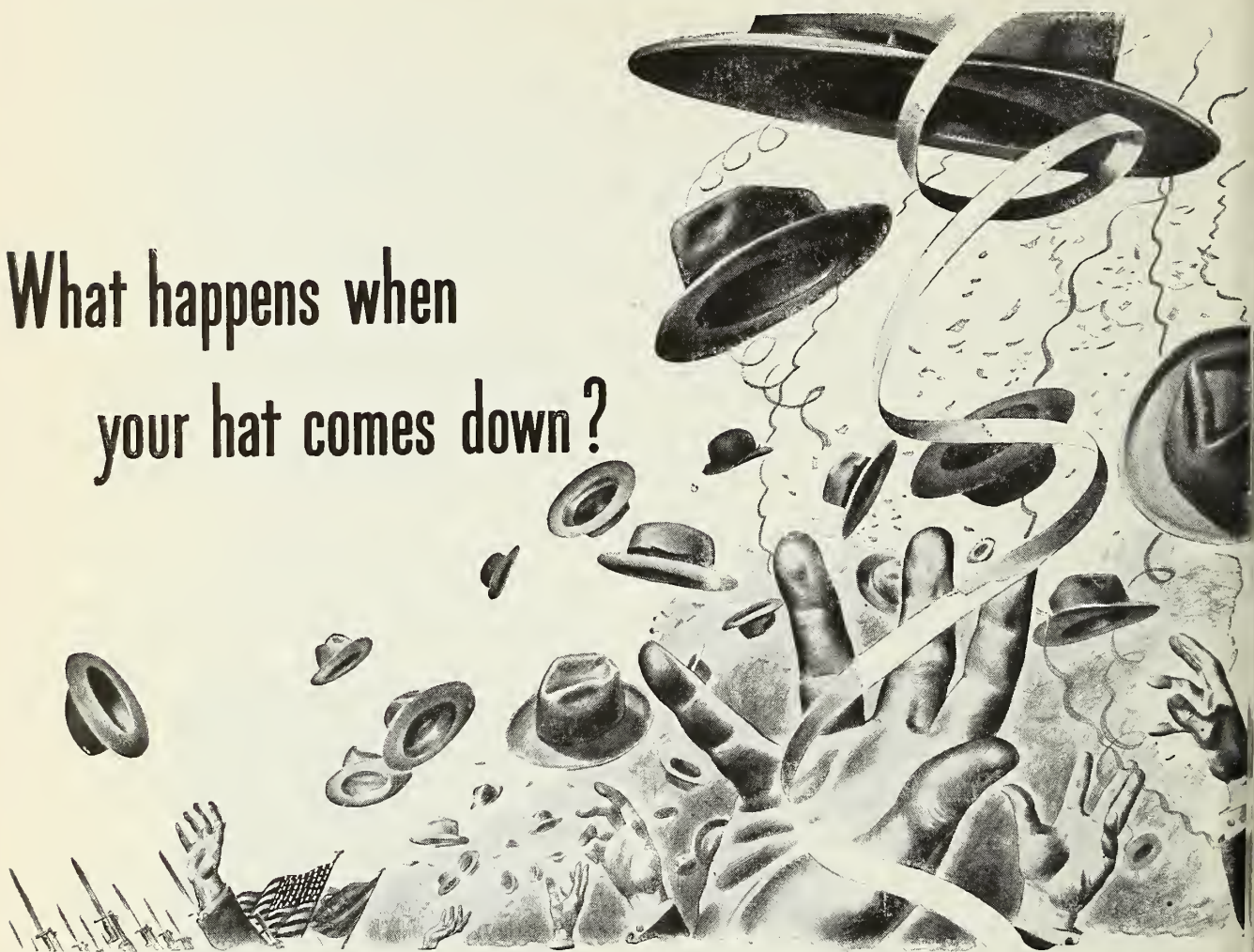
APRIL IS CANCER CONTROL MONTH



Learn the danger signals!
Get early diagnosis and
prompt treatment. Delay is
dangerous! Enlist as a Vol-
unteer in the Women's Field
Army of your State and sup-
port its activities for Cancer
Control.

**AMERICAN SOCIETY FOR
THE CONTROL OF CANCER**
350 MADISON AVENUE, N. Y. 17, N. Y.

What happens when your hat comes down?



SOMEDAY, a group of grim-faced men will walk stiffly into a room, sit down at a table, sign a piece of paper—and the War will be over.

That'll be quite a day. It doesn't take much imagination to picture the way the hats will be tossed into the air all over America on *that* day.

But what about the day after?

What happens when the tumult and the shouting have died, and all of us turn back to the job of actually making this country the wonderful place we've dreamed it would be?

What happens to you "after the War?"

No man knows just what's going to happen then. But we know one thing that must *not* happen:

We must *not* have a postwar America fumbling to restore an out-of-gear economy, staggering under a burden of idle factories and idle men, wracked with internal dissension and stricken with poverty and want.

We must *not* have breadlines and vacant farms and jobless, tired men in Army overcoats tramping city streets.

That is why we must buy War Bonds—now.

For every time you buy a Bond, you not only help finance the War. You help to build up a vast reserve of postwar buying power. Buying power that can mean millions of postwar jobs making billions of dollars' worth of postwar goods and a healthy, prosperous, strong America in which there'll be a richer, happier living for every one of us.

To protect your Country, your family, and your job *after* the War—**buy War Bonds now!**

Let's all **KEEP BACKING THE ATTACK!**

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THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1021 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

MAY, 1944

NUMBER 5

GLAUCOMA

A Review of Symptoms

E. L. VAN BUSKIRK, M.D.

LAFAYETTE

Glaucomatous eye diseases represent from 1 to 2 per cent of all ophthalmic cases. Statistics show this same percentage in all countries of the world, independent of race and evenly distributed between the sexes. In the United States there are 120,000 totally blind individuals; 25 per cent, or 30,000 individuals, are totally blind as a result of glaucoma.

A well-advanced case of glaucoma will present a triad of diagnostic signs: (1) cupping of the optic disc; (2) fall in normal acuity of central vision; (3) characteristic visual field changes with which all physicians are familiar. An attack of glaucoma leaves the eye permanently damaged, and given time for the evolution of the glaucomatous triad of signs—whether due to simple or congestive glaucoma—the eye will be doomed to almost certain blindness. Glaucoma cannot be cured, but it can be arrested by medical or surgical treatment. The disease is always present in glaucomatous eyes, and the least slip in the treatment on the part of the patient may endanger the future vision of the affected eyes. Glaucoma must be recognized early during the prodromal period. The family physician has an excellent opportunity to direct to an eye physician the patient with suspicious early glaucomatous symptoms. It is interesting to note here that 20 per cent of all persons obtain their glasses from eye physicians. Another 40 per cent obtain their lenses from optometrists or opticians. Many of these non-medical refractionists are skillful and can detect early glaucoma, and will direct their patients to well-qualified eye physicians for eye treatment, but unfortunately the majority of the non-medical refractionists are unable to recognize pathological eye conditions. The remaining 40 per cent of individuals buy their lenses “over the counter.” Therefore, about 80 per cent of all people over forty years of age do not have the benefit of an eye

examination that would detect the presence or absence of glaucoma.

At the age of forty and forty-five years, all individuals need glasses for near work. The eye examination made at this time must include a complete history of all eye symptoms, an ophthalmoscopic examination of the fundus, and examination of the anterior segment of the eye with the biomicroscope and slit lamp along with tests to improve the visual acuity with correcting lenses. If glaucoma is present, it must be recognized. The ocular tension must be measured, and if found to be normal, a provocative test, such as the dark room or mydriatic tests, is advocated in order to determine the normal or abnormal effect on the ocular pressure. A study of the visual field, both peripheral and central, should be included, and the angle of the anterior chamber should be investigated by gonioscopy (described elsewhere in this issue by Dr. B. J. Larkin), if this instrument is available.

Glaucomatous eye conditions are uncommon before forty years of age, but are increasingly common during the fourth, fifth and sixth decades of life, when the wear and tear of overwork and the harassing vicissitudes of life are taking their toll. Infections have entered the body, and a variety of toxic and other influences have set up a cardiovascular-renal degeneration.

The term “glaucoma” embraces a whole group of pathological eye conditions which have the common feature that their clinical manifestations are to a greater or lesser extent dominated by an increase in the intra-ocular pressure and its consequences. Glaucoma may be classified into two groups: *secondary glaucoma*, wherein the symptom of increased intra-ocular pressure is due to some obvious ocular lesion which is known; and *primary glaucoma*, wherein the symptom of raised pressure is

due to the presence of an unknown intra-ocular disease.

The purpose of this paper is to present the symptoms of primary glaucoma. From a clinical point of view, it is convenient to divide primary glaucoma into two main groups, simple glaucoma or compensated glaucoma (Elschnig), and congestive or uncompensated glaucoma, each of which presents a completely different clinical picture of primary glaucoma. The differentiation rests upon the adaptability of the circulation of the eye to accommodate itself to the tension. If the increase in the tension is slow and insidious, even though high, there will be no evidence of redness or congestion and the vision may be almost completely lost before the patient is aware of the fact that something is amiss. In congestive glaucoma the symptoms may be precipitated suddenly due to an emotional disturbance or acute upper respiratory infection, where the eye is unable to adapt itself to the circulatory changes and becomes violently congested. All varieties may be met, from that of the fulminating disease which in a few short hours hurries the eye through a stormy, painful course into endless blindness, and that of the simple, compensated or non-congestive form, the importance of which is too often underrated and dallied with both by the patient and his medical adviser. The terrible danger of the latter form lies in the fact that the symptoms and signs are so inconspicuous that they are often overlooked or misinterpreted.

SIMPLE NON-CONGESTIVE GLAUCOMA

Simple glaucoma develops slowly, quietly and insidiously, and may have arrived at a far-advanced stage before a change occurs in the appearance of the eyes or before subjective symptoms of eye pain or discomfort, headaches or functional inefficiency appear. Signs of inflammation or congestion are completely absent, and the eye is white, apart from an enlargement of the anterior ciliary vessels at their points of perforation of the sclera. The anterior chamber is frequently shallow, the pupil somewhat dilated and responding sluggishly, although it may retain its normal size and reactions for a long time. The iris is often atrophic in a patchy manner, showing some degree of ectropion of the pigment layer. Good central visual acuity, although not as good as previously recorded, is retained to a very late stage, while the shrinkage of the visual field and the development of a wing-shaped blind area at the point of entrance of the optic nerve impair the functional efficiency of the eye, causing patients to complain that they feel as if they were looking down a tube, and thus are unable to avoid objects which they meet when on the move. Consequently, they look back and forth when walking across a room. On the other hand, a severe decrease in central vision would lead the clinician to suspect one or more acute congestive attacks during the course of the simple glaucoma. The disease is a bilateral one, although one eye may be affected before the other. An attack of simple

glaucoma may pass into a congestive phase at any time. The fact that it has not shown a tendency to do so previously, during a period of years, is not an absolute guarantee for the future. Furthermore, the disease may after the close of a congestive attack lapse into a close imitation of the simple form. A patient may show in one eye the phenomena of simple glaucoma, and in the other eye congestive glaucoma.

The diagnosis of early simple glaucoma is a problem of utmost difficulty, but always of greatest importance. Suspicious symptoms in borderline cases are rapidly increasing presbyopia—requiring frequent changes of glasses, headaches or fleeting attacks of blurred vision, the appearance of halos around lights, and a feeling of fullness in the eye which may appear on awakening or after a stay in the dark, as in a movie theater, or even after slight vasomotor disturbances, such as a warm bath or the taking of stimulants—coffee, alcohol, et cetera.

The question of tension must be considered, and it cannot be too strongly emphasized that in the diagnosis of early, simple glaucoma the finding of a normal or even a subnormal tension on one or more occasions is no criterion that glaucoma does not exist. If an investigation of the diurnal variation in tension is not undertaken in order to learn the highest point reached by the intra-ocular tension, which occurs at 3:00 to 4:00 A.M., then provocative tests, such as the dark room test and mydriatic test (euphthalmine), are advocated to elicit the abnormal rise in tension.

PRIMARY CONGESTIVE GLAUCOMA

The clinical course of an attack of primary congestive glaucoma may begin without warning; more often it is heralded by the prodromal symptoms or it is engrafted upon and complicating an attack of chronic, simple glaucoma. The prodromal symptoms consist of transient periods of misty vision that may last even for several hours at a time, associated with some degree of eye pain and headache. The appearance of rainbow-like rings around bright lights viewed in the dark, together with other photopsia, such as flashes of light which may resemble summer lightning flashes, or a ball of red light rolling slowly in front of the eye, or flashing points of light, may seem amusing to the patient rather than a warning of an impending attack of glaucoma. Objective examination at this time would reveal a steamy cornea and a shallow anterior chamber along with a dilated pupil and an increase in the intra-ocular tension. A sudden increase in presbyopia is noted. The ocular media is hazy, making ophthalmoscopic examination difficult.

These attacks can usually be traced to periods of bodily exhaustion, sleeplessness, and mental worry. Like asthenopic symptoms, they commence in the morning and wear off as the day advances, or they may come on as fatigue deepens in the late afternoon or evening.

The progress of degenerative or other eye changes is monthly, weekly or daily, forming an increasing barrier to the exit of the intra-ocular fluid, and the time is rapidly approaching when the delicate balance between input and output will raise the intra-ocular tension to the danger point, at which time the vascular circulation will be seriously interfered with. The duration of this early stage varies, depending on the individual excreting channels of the eye, but sooner or later it passes into a well-established attack of congestive glaucoma. This new phase of the disease is ushered in by a crisis which is frequently accepted as the date of onset of the disease.

The leading symptoms are a severe trigeminal neuralgia, usually referred to the eye and forehead, rapid impairment of vision, and marked constriction of the visual field.

Examination of the eye reveals severe circumcorneal congestion; the cornea is steamy and insensitive, the pupil is widely dilated, oval in shape, and greenish blue in color. The anterior chamber is shallow, and the iris appears to be discolored due to edema of the iris and the cornea. The eye is very tender and stony hard. Severe gastric disturbance of nausea and vomiting are often associated with the attack of congestive glaucoma.

After a varying period of hours or days the symptoms subside and the acute stage passes off, but the eye is permanently damaged. The eye may pass into a chronic or into a subacute stage, but the relentless course of the disease persists with more or less frequent exacerbations.

The disease process has now reached the stage where every sign of a well-advanced glaucoma is present. The visual acuity is markedly diminished, a large nasal field defect is present along with a severe visual field constriction, the intra-ocular tension is elevated, but not as high as during the acute exacerbation of the congestive phase of the glaucomatous attack. A mild circumcorneal zone

of congestion is present, and the perforating blood vessels are enlarged at their points of exit and stand out clearly against the sclera. The cornea is clear between attacks, but easily clouds over, and it is insensitive and anesthetic. The anterior chamber is shallow and the iris angle is completely occluded and obstructed. The pupil is moderately or widely dilated and oval in shape in its vertical meridian. The iris is sluggish and may be discolored or partially atrophic. The optic nerve is cupped and surrounded by its glaucomatous halo or ring of retinal atrophy. The retinal arteries are constricted, while the veins are dilated, and vascular pulsation may be detected.

Pushed on at first gently, gradually and imperceptibly on its downward course, and hustled later by congestive attacks, the eye passes on to blindness. Sometimes the intervals of hopeless gloom are lightened by a luminous haze, which may last for hours or even days at a time, or a patient may have such power of reflection or recollection that visual impressions stored in the cerebral cortex may enable him to summon these shadows and insist that he can sit at a window and see objects.

The degenerative phase is the last stage in the course of primary glaucoma. At this period the cornea is vascularized with glassy-looking deposits in the cornea and vesicle formation beneath the epithelium, cataract develops, and finally the eyeball may shrink and become phthisical.

The progression of the degenerative process of glaucoma can be checked and the ultimate blindness of glaucoma can be prevented if glaucoma is recognized early. Persons past forty years of age should have the benefit of a thorough eye examination in order to establish the presence or absence of glaucoma. Medical and surgical treatment of glaucoma is directed toward keeping open the filtration angle of the anterior chamber. As long as filtration is maintained the intra-ocular tension can be controlled and the degenerative glaucomatous process can be arrested.

ABSTRACT

STREPTOCOCCIC DISEASE IN A COMMUNITY

Reporting a study in an Army camp in which was determined the incidence of scarlet fever due to various strains of hemolytic streptococci, Morton Hamburger, Jr., M.D., Field Director of the Army Medical Department's Commission on Air-Borne Infections, and Carolyn H. Hilles, M.S.; Virginia G. Hamburger, B.S.; Margaret A. Johnson, M.S., and Joanna G. Wallin, B.S., Camp Carson, Colorado, point out in *The Journal of the American Medical Association* for February 26 that "The establishment of the relative ability of various strains of hemolytic streptococci to produce scarlet fever is of considerable

epidemiologic importance. Scarlet fever is a reportable disease in practically all communities whereas other forms of streptococcic disease are not. If the ratio of cases of scarlet fever to the total cases of streptococcic pharyngitis-tonsillitis can be established for the various serologic types, a yard-stick will be available for the estimation of the total amount of streptococcic disease in a community during a given season. The information provided by such estimations would be of great value in the study of the epidemiology of rheumatic fever and other conditions associated with the hemolytic streptococcus. . . ."

GONIOSCOPY

BERNARD J. LARKIN, M.D.

INDIANAPOLIS

Gonioscopy, the study of the angle of the anterior chamber, is no longer confined to the scientific research worker but is becoming a routine examination in the clinic and in many private offices. It has been very helpful in the medical and surgical treatment of glaucoma.

As far back as the last year of the Nineteenth Century, Trantas,¹ a Greek ophthalmologist working in a Hellenic hospital in Constantinople, published a paper in a French journal, the translated title of which was "A Method of Exploration with the Ophthalmoscope and by Translucidity the Ciliary Circle in the Anterior Portion of the Ocular Fundus." Trantas' method was almost as complicated as the title of his paper, but in any consideration of gonioscopy his name should be kept in remembrance. When others had succeeded in perfecting instruments which made possible the visualization that he failed to obtain, he had at least the satisfaction of knowing that they had but built on the foundation, the first stone of which he had laid.

Salzman² (1914) has been called the "father of gonioscopy" by many, notably by Jacques Mawas³ in his *Biomicroscopy of the Anterior Chamber* because he was the first ophthalmologist to make a systematic study of the optics of gonioscopy. By placing a Fick's contact lens upon the cornea, he was able to get a better view of the chamber angle.

Far better than anything accomplished by Salzman were the angular microscope devised by Koeppe⁴ and the gonioscope of Troncoso.⁵ Koeppe in 1920 published a method for the use of the slit-lamp and corneal microscope constructed by Zeiss, with an objective lens system providing stereoscopic vision. Both Salzman's and Koeppe's methods required considerable dexterity and expensive equipment.

To Uribe M. Troncoso belongs the present interest in gonioscopy, for in the twenties he published in *The American Journal of Ophthalmology* a description of his hand monocular gonioscope with axial illumination for the study of the angle.

Mawas's book was published in 1928. By that time gonioscopy had become a well-recognized procedure, although the *Surgeon-General's Index* made no mention of it. The medical dictionaries likewise remained proudly aloof until 1938, when Dorland for the first time inserted the name of the instrument and the name of the technical procedure in which it is employed. *The Surgeon-General's Index of 1940* referred the reader to "EYE, Anterior Chamber; Examination of," and if the seeker had sufficient perseverance he could find thereunder a truly imposing array of papers and theses devoted to various phases of gonioscopic technique.

As one reckons time in the scientific cycle, gonioscopy is one of the youngest offshoots from the ophthalmological tree; however, it is growing and branching remarkably, so much so that merely to examine accumulated literature is quite a formidable task.

Gonioscopy may be defined as the biomicroscopic study or examination of the region of the angle of the anterior chamber of the human eye. The gonioscope designed by Troncoso has remained an efficient means of making such examinations, and the monograph by Troncoso and Castroviejo entitled "Micro-anatomy of the Eye with the Slit-lamp Microscope" is the most complete exposition of the field of study encompassed in the term so far placed at the disposal of ophthalmologists. Barkan,⁶ of San Francisco, has made valuable use of these studies in his work on glaucoma, and has devised improvements which have simplified the examination process and increased the ease and accuracy of diagnosis. In his own words:

"Our purpose was to obtain a highly-magnified stereoscopic view of the angle of the anterior chamber with slit-lamp illumination and with equal ease throughout the whole circumference of the angle, in a short space of time and without discomfort to the subject. For this purpose we devised a method of using the Zeiss binocular corneal microscope and the Vogt slit-lamp so adjusted that the method answers the above conditions and affords a true picture of the angle, its topography, and its tissue elements. One obtains thereby an extraordinarily complete physical conception of the structures, relationships and tissue elements of this region (including the zonule, ciliary processes, and so forth, where a coloboma is present), such as one cannot obtain in any other way. By directing a

¹ Trantas, M.: Moyens d'explorer par l'ophtalmoscopie —et par translucidité—la partie antérieure du fond oculaire, le cercle ciliaire y compris., *Arch. d'opht.*, **xx**:314, (June) 1900.

² Salzmann, M.: *Die Ophthalmoskopie der Kemmerbuch* Zeitsch. f. Augenheilk., Vol. 31 and 34. 1914.

³ Mawas, Jacques: *Biomicroscopie de la chambre antérieure de l'iris et du corps ciliaire*. Chap. III, pp. 44-53. Paris: Masson et Cie, 1928.

⁴ Koeppe, L.: *Graefe's Arch. f. Ophth.*, **101**:48-238, 1920.

⁵ (a) Troncoso, U. M.: The Physiologic Nature of the Schlemm Canal., *Am. J. Ophth.*, **iv**:321. (May) 1921.

(b) Gonioscopy and Its Clinical Applications, *Am. J. Ophth.*, **viii**:433, (June) 1925.

⁶ (a) Barkan, Otto, et al.: On the Genesis of Glaucoma, *Am. J. Ophth.*, **xix**:209, March, 1936.

(b) Barkan, Otto: Glaucoma: Classification, Causes, and Surgical Control: Results of Microscopic Research, *Am. J. Ophth.*, **xxi**:1099, (Oct.) 1938.

light upon the sclera posterior to the limbus (posterior gonioscopy of Trantas), the angle can also be examined by transillumination, further observation made, and confirmation obtained of appearances as seen by direct illumination."

It has been emphasized that gonioscopy is a study of the human eye. This is because the anterior angle in the eyes of man and the primates generally is essentially different from that found in lower orders of animal life. This is the reason animal experimentation was never helpful when exploration of the angle was attempted before the invention of the gonioscope. These differences are well shown in the splendid monograph of Troncoso and Castroviejo,⁷ to which reference has been made. These illustrations show embryonic development—how the mesodermal reticulum eventually becomes the stroma of the iris in the earliest stage of development, completely filling the space which will later on be the anterior angle with the important canal of Schlemm. As the mesodermal tissue regresses, the angle is gradually opened but remains lined with a tissue which embryologists designate as "the meshwork of the angle of the anterior chamber." This has a scleral portion which is known as the "corneo-scleral trabeculum," and an uveal portion, made up of fine trabeculae upon the inner surface of the anterior angle's recess, together with certain coarser bands which are called "iris processes." In certain of the lower orders of animals are found "ligamentum pectinatum," rudimentary structures, which would seem to correspond to the uveal portion of the human angle's lining, possibly because they lost or never possessed the function of lens support as in the human eye. Congenital types of glaucoma may arise when for any reason some stage of the process of intrauterine development is arrested.

Gonioscopy makes possible examination of a portion of the human eye which remained unexplored until the present century was well advanced. In certain diseases, as well as congenital malformations, its findings are especially valuable. Congenital iris coloboma and irideremia with developmental disturbances in the iris root and ciliary body, as well as tumors of these structures, congenital megalocornea and hydrophthalmos are among the abnormal conditions which can be studied by means of gonioscopy. It is possible, also, to locate small foreign bodies in the anterior chamber, to estimate the effect of injury which may have been sustained by the anterior segment, or to find synechiae, organized exudates, or other remains of the destructive effects of chronic inflammation.

It is, however, in the examination and treatment of glaucoma that gonioscopy has so far found its greatest usefulness. According to a theory brought forward by Troncoso, in the early stages of acute and chronic (i.e., uncompensated or inflammatory) glaucoma, especially when these are associated

with neurovascular disturbances, the anterior angle remains open. But in severe and long-continued glaucomatous conditions, there will be so much edema and hyperemia of the ciliary body, as well as advance of the lens-iris diaphragm, that the angle will be closed by the formation of synechiae.

The angles are open in the large majority of compensated or noninflammatory cases of glaucoma, although many subjects have chambers so shallow that gonioscopic investigation is impossible. Barkan, writing in 1938, stated that he had found the angle open in considerably more than half of his compensated cases (60 per cent). This author believed that the cause of most cases of glaucoma which are found to be compensated resides in sclerosis of the trabeculae, as well as invasion of the corneoscleral trabeculum's spaces by pigment granules. Sugar⁸ says that in gonioscopic examination of a patient with but one eye affected with glaucoma capsulare (the other eye being entirely normal), there may be no trabecular pigment in the unaffected eye while it is invariably present in the glaucomatous eye. Yet Sugar claims "it is debatable whether the pigment causes glaucoma by blocking the trabecular spaces, whether the pigment results from pigment epithelial degeneration as a result of the glaucomatous process, or whether it is coincidental in patients of the age group considered"—that is, those who had reached an age where senile changes, such as pigment migration and degeneration, might be expected to take place in eyes not affected with glaucoma.

Kronfeld⁹ does not believe that the lesser degrees of pigmentation indicate impaired function of Schlemm's canal, and even goes so far as to say that "in the presynechial stage of ordinary primary glaucoma with moderately deep chamber, gonioscopy gives no clue regarding the mechanism of glaucoma." Kronfeld has found gonioscopy valuable in many ways, especially for pre- and post-operative observation. "One important lesson that gonioscopy has taught us," he says, "is that absence of the anterior chamber for several days invariably entails the formation of peripheral anterior synechiae which are not essentially different from those adhesions that develop spontaneously in primary glaucoma. Such synechiae may develop in any case of intra-ocular surgery after which the anterior chamber remains collapsed for several days. Their extent in meridional direction appears to be dependent upon the duration of absence of the anterior chamber. Soon after the trephine operation the chamber tends to be abolished for longer periods

⁸ (a) Sugar, H. S.: Concerning the Chamber Angle; 1. Gonioscopy, *Am. J. Ophth.*, **xxiii**:853, (Aug.) 1940.

(b) Practical Applications of Gonioscopy to Surgery, *Am. J. Ophth.*, **xxv**:663, (June) 1942.

⁹ (a) Kronfeld, P. C.: Practical Value of Gonioscopy, *Wisconsin Med. Jour.*, **xI**:681, (Aug.) 1941.

(b) Kronfeld, P. C., et al.: Gonioscopic Studies on the Canal of Schlemm, *Am. J. Ophth.*, **xxv**:1163, (Oct.) 1942.

(c) Kronfeld, P. C., and McGarry, H. I.: Present Limits of Gonioscopy, *Am. J. Ophth.*, **xxvii**:147, (Feb.) 1944.

⁷ Troncoso, U. M., and Castroviejo, R.: Microanatomy of the Eye with the Slit-lamp Microscope, *Am. J. Ophth.*, **xix**:371, 481, 583, 786. 1936.

than after iris-inclusion operation without sclerectomy, the postoperative synechiae are most marked after trephine operation These postoperative adhesions are one example of the value of gonioscopy for the evaluation of operative results."

I hope that what I have been able to tell you will give some idea of the value of this relatively new procedure—gonioscopy. If it did no more than

make it possible for the practicing ophthalmologist to get a better conception of the anatomical and histological structure of the eye, it would be well worth his time to become proficient in its technique. It has many more important uses, and even more are being found as those who practice it attain more skill and better understanding of its applications.

EYE ACCIDENT MANAGEMENT

J. V. CASSADY, M.D.

SOUTH BEND

It is estimated that there are about three hundred thousand eye accidents annually in the United States that involve one or more days' loss of time. Eye accidents involve a direct cost of thirty to thirty-seven million dollars each year, an indirect cost of an equal amount or sixty million dollars combined direct and indirect cost. Of all industrial accidents, 17 per cent involve the eye. There are more eyes lost than legs, arms, hands and feet combined, and most of these accidents are preventable. Approximately 15 per cent of the American blind lost their sight because of industrial occupational hazards.

A reduction in the frequency and seriousness of eye accidents depends upon safety measures, not only in industry but among individual workers, farmers, housewives and children. Protection from sharp-pointed sticks, knives, scissors, air rifles, rubber band shooters, sling shots, and fireworks by an eye-conscious public is necessary to reduce eye accidents. Provision of protective equipment (goggles, masks and shields), work rules, supervision, training and education of the worker regarding safety measures and revision of work processes, machinery, tools, and other plant equipment to reduce eye hazards are all part of the campaign for reducing the number and severity of eye accidents.

Many eye injuries are now being handled by general physicians because of the lack of available eye specialists in newly-developed industrial communities which have sprung up in former agricultural areas during the present war. The general physician, the one who occasionally sees and manages eye cases either in a first aid or more extensive role for industry, should have a fair knowledge of eye management. Medical schools should require a broader knowledge of the eye and its injuries, especially since most of their young graduates are going to see active war service. In writing this paper the author is mindful that it is embodying no new principles for the oculist or industrial surgeon, but is hoping that it may be helpful in reviewing for the general physician, young or old, some of the principles of the management of eye injury.

Among eye hazards are flying particles of metal, stone, wood, glass, dust, ashes, coal or emery,

burns with acid, alkali, heat, lime, battery acid, or molten metal. If a segment of a sphere strikes the eye with its convex side it usually does not stick but is swept off by the lids or tears. If the concave side strikes, it adheres to the cornea, conjunctiva, or sclera where it contacts. Conjunctival foreign bodies are quite common, are painful, and incite more lacrimation and tearing than corneal foreign bodies. To remove them the eye may be irrigated with boric acid solution, and the lower lid and cul-de-sac searched. If it is not located, evert the upper lid where it is usually found in the subtarsal sulcus close to the free margin. The superior cul-de-sac may be explored by pressure upon the everted lid border while sweeping the free margin of the lower lid across the superior fornix.

Multiple conjunctival foreign bodies from an explosion or fire accompanied by singeing of the eyelashes may be treated by generous irrigation of the conjunctival sac, which results in the cleaning of the lid margins and lashes of dirt particles. This should be followed by careful search and investigation of the conjunctival sac. Then leave the eyes open, don't bandage them; allow nature's tears to help irrigate them. If the cornea is involved, remove the foreign bodies from this also and instill a solution of 1 per cent homatropine or atropine, covering the eyes with a dressing.

Burns of the conjunctiva with chemicals demand prompt washing of the sac with water whether they are acid or alkaline. The immediate irrigation of the eye probably is much more important than any medication or treatment administered by the physician an hour or two after the chemical burn. The eye should be irrigated again with boric acid solution. At this time a search should be made in the upper and lower lid fornices for any particles of acid, alkali or lime. The eye should be washed again with a solution of 1 per cent homatropine or atropine, and the patient sent home for cold compresses without bandages or any local anesthetic agent. More harm may be done by the latter at this stage than by the original chemical burn. Nature needs the eye open to wash it out with tears. Some sedative by mouth, if necessary, is much more appropriate than a local anesthetic

taken home and used indiscriminately with its deleterious softening effect on the cornea. If the conjunctival burn is deep, there is grave danger of symblepharon. Either boric ointment or butesin picrate ointment should be used to prevent this. Refer these cases to an eye physician.

After the first-aid treatment of any eye injury, and before a patch is applied and the patient dismissed, always measure and record the vision in each eye. The injured person is always anxious that there be no impairment of visual acuity, thus its record at this time will be much more valuable than at subsequent examinations. Vision should be recorded as that of right eye and left eye, with and without correcting lenses.

Corneal foreign bodies are the ones that usually reach the physician's office. Conjunctival foreign bodies are often removed by a friend or fellow employee and are not seen by the physician. Every physician who intends to remove corneal foreign bodies should have a loupe (monocular or binocular), a condensing lens, good focal illumination, and an eye spud. If the foreign body is not readily visible, have the patient look in various directions so that the cornea may be examined at a tangent. Fifty-four per cent of foreign bodies which strike the cornea are hot, leaving a burn. If the foreign body is not seen, drop one per cent fluorescein into the eye and wash it out with boric solution, when the foreign body or its abrasion site will stain a greenish hue.

Foreign bodies of the cornea should be removed early to prevent inflammation, ulceration, and necrosis. The oxidized ring should be removed along with the foreign body. The latter can best be removed with an eye spud, the former with a small dental bur which smoothes out the crater and removes the rough edges and ring of rust. A local anesthetic (2 per cent butyn, $\frac{1}{4}$ of 1 per cent pontocaine, 1 per cent holocaine, or 2 to 5 per cent cocaine) may be dropped into the conjunctival sac of the lower lid. Have the patient keep both eyes open and fixed, removing the foreign body and its ring of rust with the aid of good illumination. Smooth the edges of the crater, instill a drop of 1 per cent homatropine or atropine and cover the eye

with an eye pad; have the patient return the following morning for examination.

If the foreign body is deeply embedded or projects into the anterior chamber, cover the eye and seek the consultation of an eye physician. If there are multiple foreign bodies, as after an explosion, remove all that you can and have the patient return the following day, when often the remainder may be more easily removed. If there is a suggestive history of an intra-ocular foreign body, a sharp pain, the presence of a flying particle, a slight eye redness, a scar on the cornea which extends through it, or a hole in the iris, send these patients immediately to an eye physician, and do not temporize.

Laceration or puncture wounds of the eye with prolapse of iris, vitreous, or lens should have a loosely-applied eye dressing and be attended at once by a skilled eye physician. Wounds of the eyelids, especially those involving the free border, should be carefully repaired. A lasting cosmetic and functionally good result depends upon accurate junction of the free border of the lid by marginal, skin, and conjunctival sutures. Fractures involving the orbit should be carefully investigated for possible penetrating bone spicules which might cause muscle or nerve injury with loss of function. Contused wounds may cause rupture of the globe, separation of the retina, or traumatic cataract.

To reduce the frequency of eye accidents is one measure to save eyesight and conserve vision. The physician should help in the campaign to save eyesight by teaching all those with whom he comes in contact the dangers of injury and the importance of eye protection. If an eye injury occurs, competent first-aid care reduces the seriousness of its sequelae. Competent medical management reduces the time lost and the incidence of corneal ulcers with subsequent corneal scars, and their resultant visual dysfunction. The general practitioner often is the first line of defense as he frequently sees the patient before he gets to the specialist. He should be able to competently institute first aid, manage the ordinary eye injury, and have the knowledge and acumen to guide the more serious cases to an eye specialist.

DOCTOR OSLER AND GOK

One day when Dr. William Osler was in London he was invited to inspect a rather famous hospital of the old town; and there he was proudly shown about by several physicians and surgeons. Finally, the charts were reached. He looked them over carefully, observed the system of therapeutic abbreviations, such as D for diphtheria, DT for delirium tremens, SF for scarlet fever, TB for tuberculosis, and so on. All the diseases seemed to be pretty well under control except one, indicated by the symbol GOK. The famous doctor did not wish to display

his ignorance, although he might have been pardoned for not being entirely *au courant* with the terminology of London hospitals.

"I observe," said he, "that you have a sweeping epidemic of GOK on your hands. By the way, this is a symbol not in common use in American medical circles; just what is GOK?"

"Oh," one of his hosts lightly replied, "when we can't diagnose, God Only Knows!"—*Life of Ambrose Bierce*, by Walter Neale.

THE ROLE OF THE FAMILY PHYSICIAN IN THE CARE OF OPHTHALMIC SURGICAL CASES

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The family physician has played the chief role in the general practice of medicine and will continue to be the hub of the medical community. The successful practice of any limited or specialized branch of medicine or surgery requires understanding cooperation from the family physician. He too often regards the eye as an unwelcome stepchild. This has resulted from an inadequate knowledge of ophthalmology and a lack of acquaintance with the spectacular in the conduct of ophthalmic surgical cases.

The individual and collective success of the human race has been in direct ratio to the efficiency of sight and to the care of the eyes available to the people. When this fact becomes more universally accepted, the medical practitioner will realize the gravity of any situation where eyes function improperly.

Surgical conditions develop in all parts of the body. The eyes are no exception. We may ask the question, "What is the role of the family physician in the care of the ophthalmic surgical patient?" I shall try to answer that question.

The patient consults the family physician before he seeks advice from another source. Early recognition of an ocular defect is the first and paramount duty. The next is to afford prompt and efficient care.

An accurate history of any previous illness is illuminating and can be given best by the patient's own physician. A careful physical examination must be conducted. Any disease or affliction that disturbs the comfort and self-control of the patient, or that may interfere with proper healing of tissues, presents special problems for their control. Allergic states and diseases of the skin, circulatory, respiratory, digestive, or genito-urinary systems must be controlled before a successful convalescence from any major operation can be assured. The ophthalmic surgeon who is forewarned will be the better prepared to meet the emergency.

In my experience a patient who had undergone removal of cataract developed swelling and intense itching of the eyelids on the fourth postoperative day. This was produced by certain flowers that had been received that afternoon. Removal of the flowers from the room gave prompt relief. In that way I discovered the allergy.

Improper eating habits and intolerance of some foods may upset the digestive tract and lead to avoidable complications. An acute attack of cholecystitis may provoke vomiting and intra-ocular hemorrhage. If the patient is suffering from diabetes, it is important to know the diet and the

amount and kind of medication required to properly regulate the metabolism of fat and carbohydrate foods. Surgery upon the eye of a diabetic person constitutes a greater risk than for one who is not diabetic. Recently a patient came for removal of cataract, with a statement from the family physician that the physical condition of the patient was suitable for the operation. Examination of the urine showed the presence of 3 per cent sugar. The operation was postponed. In suspected cases the blood sugar should be determined, even though the urine is negative.

Vascular hypertension increases the risk involved for any intra-ocular operation. Most ophthalmologists consider a systolic pressure of 165 to 170 as the upper limit of safety. The diastolic pressure should not exceed two-thirds of the systolic pressure, and never be above 100. If the blood pressure is above those figures, measures should be employed to reduce it before the operation is performed. The danger is that of intra-ocular hemorrhage during or after the operation, which may destroy the eye or seriously impair its function. If the blood pressure can not be reduced to within safe limits, the patient and family should be advised of the hazard prior to operation.

The person who suffers from some chronic ailment of the respiratory tract may need an operation upon the eye. Diseases of the respiratory tract that cause coughing, such as chronic bronchitis, may require heavy sedation for the control of the cough for the first few postoperative days, and the surgeon may use additional sutures to reinforce the closure of the operative wound. Additional safeguards increase the chances of success.

Prostatic enlargement may cause urinary retention, so that measures must be taken to relieve this situation. If the eye is to receive surgical attention before the prostate is to be resected, the use of a retention catheter should be considered.

A recent injury of the eye or eyelids can be protected best by placing a dry, sterile eyepad over the injured eye without the use of solutions or ointment. Then the patient is admitted to the operating room. One should not overlook the possibility of a penetrating wound in what may appear to be a trivial superficial injury. Small wounds may signal the site of entrance of an intra-ocular foreign body with all of the associated dangers.

Parents of a child who has or is developing strabismus should be advised to consult an ophthalmologist at once, and not to delay until the child has entered school. Early attention to strabismus

cases can prevent a few from having to undergo an operation upon the ocular muscles. If an operation proves necessary, it should be done early rather than late, and then follow it by whatever orthoptic exercises and other measures are indicated.

The family physician has a responsibility in the proper conduct of ophthalmic surgical cases in their early recognition, knowledge of the family and personal history, and in conducting an efficient physical examination.

TUBERCULOSIS AND THE EYE

H. BROOKS SMITH, M.D.*

BLUFFTON

Tuberculosis of the lungs is a disease recognized, dreaded, and treated by a great number of medical men. Tuberculosis affecting the eye is just as much to be feared, although it is seldom recognized. Furthermore, the treatment of ocular tuberculosis has been so poorly understood that not more than a handful of men in Indiana would undertake to treat the disease.

During these years when ophthalmologists are becoming scarcer than the proverbial hens' teeth, it behooves the general practitioner to think a bit about tuberculosis of the eye, for into his office will come many such patients. If tuberculosis which involves the iris and uveal tract is not recognized quickly, irreparable damage will be done to the patient's vision. Patients suffering with advanced tuberculous eye diseases are constantly drifting into the hospital clinics, where a diagnosis is finally made but too late to save useful vision. No attempt will be made in this paper to give detailed methods of diagnosis or treatment, but it is hoped that enough can be said to make each reader think of tuberculosis when eye conditions such as will be enumerated appear in his office.

TYPES OF TUBERCULOUS INVOLVEMENT

Tuberculosis affects the eye in two ways. First, as the simple tuberculous ulceration in which the tissues break down from the actual presence of the bacillus, and from which cultures and biopsy material will recover the organism. Secondly, and by far the most common involvement, is one of an allergic nature in which the ocular tissues become sensitized to tuberculo-protein. Here, too, there is breaking down of tissue with ulceration and repair, but the bacilli are not actually present in the lesion. In former years there has been a question of doubt as to whether this second group really existed, but since Woods and Friedenwald, of Johns Hopkins Hospital,^{1, 2} have published reports on their experiments in sensitizing eyes to tuberculo-protein and of their success in desensitizing eyes to the same substance, there need be no question of its validity.

FIRST GROUP CHARACTERISTICS

The general characteristics of simple tuberculosis of the eye are the chronicity, freedom from pain, and the tendency to produce yellow avascular tubercles which break down into punched-out ulcers with a hard, smooth edge. Any portion of the eye and orbit may be involved, although the lids, tear sac, and cornea are the most frequent sites.

Tuberculosis of the conjunctiva and the lids usually is seen in young people who either have pulmonary tuberculosis or who have been in close contact with persons suffering from such disease. The tubercle bacillus is present in the tissues. An elevated inflamed mass which caseates in the center is seen. The ulcer is covered with fibrin and crust, and when this is removed granulations are seen to protrude from the base of the ulcer. The edges are irregular and punched out, and a very mild induration surrounds the ulcer. There is no tendency to heal. The preauricular glands are painlessly enlarged on the side of the face involved. Often such a lesion starting on the lower lid about the lacrimal punctum will slowly and painlessly destroy the lid, the tarsal plate and the tear sac, and extend onto the eyeball itself—all because it did not hurt; the patient thought it was a mild infection, and it wasn't wild enough to spur the doctor into doing something about it.

At the other extreme is the doctor who diagnoses a cancer in such a lesion and does a complete excision of the lesion, only to find on biopsy report that it is not cancer but tuberculosis. Such a procedure, while in the nature of a mistake, is, however, justified in that it certainly removes the lesion. Scientific diagnosis is to be made by guinea-pig inoculation.

This same type of lesion may appear on the eyeball and be associated with an interstitial keratitis and an episcleritis. Pain and photophobia are present when the cornea is involved, and if there is actual breaking down of the cornea the pain is terrific.

Tuberculosis involves the iris directly and is characterized by the formation of yellowish nodules about the base of the iris. These grow slowly and vision is not affected until the tubercle ruptures through the anterior surface of the iris with the

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¹ Woods and Friedenwald: Studies of Ocular Tuberculosis, *Arch. Ophth.*, February, 1938.

² Woods and Friedenwald: Studies of Ocular Tuberculosis, *Arch. Ophth.*, February, 1940.

extrusion of cells, blood and fragments into the anterior chamber. Vigorous treatment, with atropine, is necessary at this state to open the pupil widely so that posterior synechia will not produce a secluded pupil. The settling of this cellular debris over a tiny pupillary aperture will produce irreparable loss of vision. Such a process is often slow in developing and is painless until rupture of a tubercle sets up the acute iritis. Often these cases, for want of a better diagnosis, are carried along as a cold in the eyes, rheumatism of the eye, et cetera, when all that one need do to diagnose tuberculosis is to examine the iris root by focal illumination and a loupe.

The same picture presents itself in the choroid and retina. Tubercle bacilli come by the blood stream from a breaking down of tubercles elsewhere in the body, often in the terminal stage of a miliary tuberculosis. They lodge in the choroid and are easily seen ophthalmoscopically as isolated and elevated gray yellow masses beneath the retinal vessels. Miliary tuberculosis of the retina is always of grave import; if the patient survives his systemic tuberculosis, consultation of the eye physician should be sought. Treatment of this group requires careful attention to all the rules for treatment of systemic tuberculosis. If active pulmonary involvement is ruled out, the patient need not be bedridden. He should be seen by the ophthalmologist for consultation and suggestion, but care will be given by the family doctor. If the lesion is excisable, possibly a good attack is the complete excision of the ulcerating mass, but it must be possible to do this without mutilation of the structure surrounding and without deformity. Foci of infection, such as diseased tonsils, diseased teeth, infected sinuses, prostatitis, and intestinal stasis must be eliminated. Vitamins and heliotherapy have their place. Adequate diet, rest, cleanliness and care that others are not infected are essential.

GROUP II CHARACTERISTICS

Tubercle bacilli need not be present locally to produce what we now recognize to be affections due to tuberculosis. The eye may be involved in an allergic type of reaction in which certain tissues of the eye become sensitized to tuberculo-protein from elsewhere in the body. Indeed, most patients with this type of involvement do not have active tuberculosis demonstrable at the time of their ocular trouble. Diligent search will always reveal that the patient has had contact with the tubercle bacillus either in the lungs, in peribronchial lymphatics, in the kidney, or elsewhere. This earlier infection has sensitized the body tissues, including those of the eye, so that fresh contact with tubercle bacilli does not produce the lesion previously described in Group I but produces an allergic reaction characterized by:

1. Phlyctenulosis — also known as scrofulous or eczematous keratoconjunctivitis—is a condition easily recognized. The phlyctenule is a small nodule at the corneo-scleral junction 1 to 2 mm. in

size and slightly elevated. After a few days the nodule softens and ulcerates, producing a shallow ulcer which tends to heal in a few more days—leaving a tiny gray scar. Unless these ulcers become secondarily infected, the process may go on for weeks with the patient complaining only of some disturbance of vision, lacrimation and photophobia. Young children living under unhygienic conditions are most often affected. They seldom have active tuberculosis, but they have the enlarged cervical lymphatics, a purulent nasopharyngitis, and often enlarged tonsils and adenoids. Tuberculin tests are positive.

2. Sclerosing keratitis is a condition seen in persons of all ages in which a lesion in the sclera invades the neighboring cornea and converts it into an opaque tissue resembling the sclera in appearance. The condition is very chronic and may last over a period of many months or even years. There is little pain except a burning and a photophobia. A little localized redness may be present at the limbus. As a rule the patient is never seen during the period when a primary scleritis is active, but he will come in when the white cloud is visible in his cornea. If the process is not stopped the entire cornea will become opaque, with blindness resulting. Tuberculin tests are usually positive in very high dilutions.

3. Iritis, uveitis and chorioretinitis are commonly found with a causative factor of ocular sensitivity to tuberculo-protein. They are all similar in that they early produce loss of vision. Pain is present early, and if the tissue involved is anterior inflammation at the limbus is seen. Exudates and debris reduce the vision often out of proportion to the size of the lesion if it can be seen microscopically. When iritis is present the exudates are the toughest encountered in eye diseases, and if the pupil is not at once dilated widely with atropine the adhesions between the iris border and lens surface will very quickly become so firm as to defy any attempt to break them. In any iritis or uveitis, when the cause is not quickly determined, think of tuberculosis and test the patient for sensitivity to tuberculo-protein, but above all keep his pupils open while the testing is going on.

The specific remedy for all, after general measures of improved hygiene have been instituted, is old tuberculin, a powerful agent with sight-saving ability when properly used, but with equally destructive effects if not properly used.

Every doctor who comes in contact with eye diseases owes to his patients and to his reputation to know what old tuberculin is, how to use it, and what it may be expected to do.

Old tuberculin is a filtrate of killed human tubercle bacilli in which the tuberculo-protein is mixed with glycerine and concentrated. The ordinary stock package contains 1,000 mg. of tuberculo-protein per 1 cc. Properly diluted, it can be applied to a patient's skin just as any antigen in a hay-fever test to see if his tissues are sensitive to

tuberculo-protein. Finding the patient sensitive, the preparation can then be used as treatment to desensitize the ocular tissues and permit the eye lesion to heal.

Diluted old tuberculin is expensive because so many strengths are needed, and when diluted is stable only a few weeks. Every doctor should be able to make his own dilutions. From personal experience, the corner druggist can not be expected to make up the preparation. All that is necessary is the tuberculin, a graduated glass syringe, and four bottles each containing 100 cc. of sterile saline. I like to use rubber-stoppered vials, such as those used for dispensing distilled water. Five drops of phenol should be added to each vial of 100 cc. sterile saline as a preservative.

PREPARATION AND DILUTION

To bottle No. 1 add .1 cc. old tuberculin stock and shake well. This vial then contains 1 mg. per cc., and should be so labeled.

To bottle No. 2, 10 cc. from bottle No. 1 is added after an equal quantity of saline is extracted. This bottle then contains 10 mg. in 100 cc., or each 1 cc. contains .1 mg.

From bottle No. 3 extract 1 cc. of saline and add 1 cc. of contents of bottle No. 2. Bottle No. 3 then has .1 mg. old tuberculin in 100 cc., or 1 cc. contains .001 mg.

From bottle No. 4 extract 1 cc. of saline and add 1 cc. of bottle No. 3, which will equal .00001 mg. old tuberculin per cc.

Testing begins by injecting .1 cc. of bottle No. 4 *intracutaneously* in the flexor surface of the forearm. An erythema 1 cm. in diameter remaining after twenty-four hours means that this patient is sensitive to .000001 mg. of old tuberculin. If no wheal or erythema results after twenty-four hours, an injection of .1 cc. of bottle No. 3 is used, being .0001 mg. old tuberculin. If no response after twenty-four hours, .1 cc. of bottle No. 2 is used. No response to bottle No. 2 dilution indicates a low

degree of sensitivity, and .1 cc. of bottle No. 1 may be injected, which will be a dose of .1 mg. This is the maximum dose of antigen to be tried, and if there is no erythema with this strength the patient can be said to be insensitive to tuberculo-protein.

TREATMENT

If sensitivity is shown, treatment should begin with minute doses of .00001 mg. old tuberculin, given subcutaneously every five days. The dose can be increased by 5 per cent each time until the patient is receiving 1 mg. at a dose.

If at any time the eye becomes more inflamed and an exacerbation of the visible lesion is present, the dose must be reduced or held at the same value for several doses. Marked improvement should be noticed by the time a 1 mg. dose is being tolerated. This dosage must be continued over a period of months, with possibly a doubling or trebling of strength eventually. Many patients under treatment with tuberculin will after several years' treatment be able to reduce treatments to once a month.

When we remember that the treatment is for the purpose of reducing the body's sensitivity to tuberculo-protein, we understand that total dosage will vary greatly and must be guided by the patient's improvement or tendency to relapse.

SUMMARY

An attempt has been made to remind the reader that tuberculosis involves the eye in two ways. The eye may be the site of a simple tubercle during active systemic tuberculosis, or it may be affected allergically by becoming sensitive to tuberculo-protein.

The types of involvement have been enumerated, but differential diagnosis has been left for the textbook, where it belongs.

A detailed description of the preparation of old tuberculin for testing and treatment has been given so that all may be prepared to use this most valuable therapeutic agent.

ABSTRACT: REPORTS PENICILLIN EFFECTIVE IN BONE AND BLOOD INFECTION

The successful treatment with penicillin of a case of infection of osteomyelitis and septicemia with *Staphylococcus albus* is reported in *The Journal of the American Medical Association* for April 8, by O. Charles Erickson, M.D., Sioux Falls, South Dakota.

The patient, a white man aged twenty-nine, a farmer, was admitted to the McKennan Hospital, Sioux Falls, on October 10, 1943, with the complaints of weakness, chills and fever, and also pain in the right hip. Treatment with sulfonamide drugs was without any apparent benefit. On November 4 treatment with penicillin was started, with immediate improvement. Blood cultures taken daily following the inception of the penicillin treatment at no time revealed any bacterial growth. He had some febrile reactions to the penicillin, the temperature, following each injection into a vein, ranging from 102 to 106.4 F.,

for about one-half hour or so but not preceded by a chill and not causing the patient to feel at all ill. When administration was given by injection into a muscle the temperature at no time was above normal. On November 18 the patient was allowed out of bed and on the following day was sent home. When last seen the following January 4 he said he felt fine and had no complaint whatever.

Commenting on the case Dr. Erickson says that "I feel that the results obtained, to say the least, were miraculous. The patient improved almost instantly and declared that he had a feeling of well being. The febrile reactions in this case, in all probability, were due to pyrogenic substances that were in the penicillin. When the penicillin was given intravenously, violent febrile reactions were obtained, but when it was given intramuscularly these febrile reactions did not occur."

EPIPHORA

LEONARD F. SWIHART, M.D.

ELKHART

Weeping, however romantic, is not convenient, especially when done in public. Weeping is not seemly in strong men, is detested by youth, and is the constant companion of a number of eye ailments. The nervous mechanism by which emotion causes weeping is very much in dispute, but the tears still roll down the cheeks. The reflex mechanism by which a foreign body makes the eyes water is not wholly agreed upon, but a cinder wickedly placed shows results rivaling any funeral sermon. Agreeing that the eyes do water in excess of normal requirements, which is at times very provoking, let us search for some of the more common causes and their relief.

Tears are of necessity produced in the tear gland, and normally drain away through the tear points, sac, and duct into the nose. Weeping occurs when the tears flow over the lid margins onto the cheeks. Weeping occurs when too many tears are produced or when some obstruction occurs in the drainage system. The over-production of tears will be first discussed.

A moderate amount of tears is needed to keep the eyes moist and to mechanically keep them clean. It so happens that nature has made an eye cleanser, the tears, which not only washes out dirt and dust but also has a definite bacteriostatic action. No solution of eyedrops, lavage, or douche can equal the tears; in fact, they dilute and may hinder the efficacy of nature's own eyewash. Throughout the years, boric acid has carried more virtue borrowed from legend than merit. When compresses are ordered, I specifically ask that clear water be used, since it is only the heat or cold that is desired. Any salts put in the compress solution add nothing of value and may leave salt tracks on the floor wherever the compresses drip and dry. Tears are moved over the eyeball by the reflex movement of the lids, and are retained from overflowing onto the skin of the lids by the oily secretion of glands which open at the lid borders. If the flow is not excessive, the tears are largely evaporated before reaching the nasal corner of the lids.

Foreign bodies on the eyeball or under the lids produce scratching, copious tears, and light discomfort. Looking for a foreign body may leave the examiner embarrassed if he does not have sufficient light; however, with a good light any foreign particle on the cornea will show up, especially if a magnifying glass is used. If a foreign body is found in this area, I recommend that a drop of 3 per cent cocaine solution be placed on the eyeball, holding the upper lid up and instructing the patient to look downward. This allows the cocaine solution to flood over the corneal surface most efficiently. Two minutes later repeat the instillation

of another drop of 3 per cent cocaine solution, and thirty seconds later remove the foreign body, and there is no pain to the patient. The upper eyelid will already have been turned and was found not to be a causative factor, so do not forget to explain to the patient that he felt no pain except as the lid moved up and down over the foreign body. If the eye could be held open, or the lid held away from the ball, no pain or scratching would be felt. After removal, explain to the patient that when the cocaine effect wears off, the same scratchy feeling and light discomfort will return, and that this may last sixteen, twenty-four or thirty-six hours. If the eye is red and continues to hurt two days later, he is to return for inspection of the corneal wound. Any grayish-white spot at the site of the foreign body means an ulcer of the cornea, and then you had better pass the case on to a specialist if you have not had any experience in such cases. You may not be thanked for the reference, but don't pine—the other fellow will!

If nothing is found on the cornea, turn the upper lid, and turn it well enough to see high into the cul-de-sac, for sometimes a chaff or beard of grain may have worked its way high into the folds of the mucous membrane of the upper lid. An anesthetic is not necessary unless the object is imbedded and cannot be removed by simple brushing off.

For a complaint of watering and scratching of an eye, without redness of the scleral or white coat, look carefully with a magnifying glass for a small foreign body. A second foreign body found later, after removal of the first, may be the cause of continued watering and discomfort following the first visit. In a suspected foreign body, be sure to look and *look*, and *LOOK!* In my experience, no agent has been so effective in relieving the pain following removal of a foreign body as hot compresses, continued and repeated as necessary, using clear, clean, hot water. Warn the patient that scratching will continue until the corneal wound is closed. Ulcers of the cornea have not responded to sulfa drugs by mouth, in my experience. Their use locally has been most gratifying, but application thereof is more difficult than reported in the literature. Do not use the ordinarily-available sulfa drugs—harm may result.

Watery eyes with photophobia and pus discharge means conjunctivitis, produced by a pus-forming organism. "Pink eye" is an unfortunate name for this, for so many simulative conditions cause the same eye discoloration. With the presence of pus, treat the condition with 5 per cent ophthalmic ointment of sulfathiazole, placed sparingly in the conjunctival sac on the inner surface of the lower

lid, near the outer corner, in an amount less than one drop, for the closed eye cannot hold more than 1/10 of a drop. A 1 per cent solution of silver nitrate brushed over the everted lids and immediately neutralized with normal saline is very effective. Organic salts of mercury, merthiolate, metaphen, and the yellow oxide of mercury in ointment form are effective in home treatment.

Styes and abscesses are often accompanied by watering of the eyes. Proper treatment consists of treatment used in furunculosis, expression of the abscesses, and prophylactic administration to the conjunctiva. Argyrol and other forms of mild silver salts used in the treatment of eye infections are not only out of mode, but there is no indication for bacteria-killing effect. Cloth is stained by it, solutions must be less than ten days old to avoid causing irritation, and no benefit comes from its use in either eye, nose or throat conditions. Argyria will follow, and if you see a few of these you will make no claims for mild silver protein salts!

School children with red, watering eyes, producing pus, must be excused from school and treated with sulfathiazole ointment, and their playthings should be scrubbed with a soap solution—remembering that conjunctivitis is transmitted by means of hands and towels. No one shops without handling money, door knobs, touching counter tops and pressing elevator buttons. Without having just washed ones hands, it is safer to put the fingers into the mouth than into the eyes. Do not rub the eyes, and no conjunctivitis can befall, is a good truism.

If a baby is brought in with a history of one or both eyes watering—sometimes a history of pus supercedes the tearing, but in either event the complaint starts at birth—this means that there is an obstruction in the tear duct, in most cases, and is cured by one or several dilatations of the duct under an anesthetic. The dilatation should be postponed until the child is at least six months of age, for safety of anesthesia and ease of probing. These are cases to be referred to the ophthalmologist. Boric acid or other methods of treatment will not prove beneficial in the presence of stricture of the duct.

Weeping due to failure of the drainage system means that there is an obstruction somewhere in the tear points or lower down. If the tear points are too narrow, the water cannot enter fast enough to keep from overflowing. If the lower eyelid is swollen, red, and turned outward, the tear point is everted and tears cannot reach the point to be carried away. In this case the tears are made in more than normal abundance, so two factors are really causing the tearing, too many tears and an insufficient drainage system. Infections of the tear sac will hinder the passage of tears or prevent it altogether. It is generally recognized that no tear sac infection is possible unless the tear duct below is partially or completely closed. Since most of the infants with pus in the tear sac are found to have a small web in the duct which readily gives way on passing sounds, it is to be questioned how far wrong one might be to assume that if all stenoses in children properly cared for in early childhood might result in eliminating nearly all of the tear sac infections encountered in adulthood.

Ethmoid sinus infection may obstruct the tear duct and cause watering of the eyes. Exostosis may crowd the canal and prevent tears from passing. Walking out into the cold wind will cause an immediate flood of tears, even when nothing else is wrong. The reflex shock to the eye causes an excess of tears, and a spasm of the sphincter-like muscle at the end of the tear duct temporarily shuts off the escape into the nose, and tears are literally blown off the face.

We have not mentioned onions and similar synthetic gases as a cause of tearing, but—God forbid—if ever some of the new gases should be used in warfare, tearing will certainly be a strong deterrent to an enemy otherwise ready for a strong offensive.

In conclusion, eyes water because too many tears are formed, and usually you can care for this type of case. Eyes water because of blocked drainage, and this type of case had best be referred to your eye physician. It is hoped that because of its brevity, and from the viewpoint of the family physician, this article will justify its publication.

ABSTRACT

USE OF BASAL TEMPERATURE GRAPHS TO DETERMINE DATE OF OVULATION

A record of body temperatures, taken rectally daily before rising under standard conditions, is an inexpensive and simple method which very often will indicate the date of ovulation and thus the time when conception is most likely to occur, Pendleton Tompkins, M.D., Philadelphia, declares in *The Journal of the American Medical Association* for March 11. He describes charts and accompanying

instructions which can be given women so they can keep an accurate record of daily temperatures.

Dr. Tompkins' method is based on the findings of many investigators that a woman's temperature under normal conditions is lower during the first part of the menstrual month and that the transition from a low level to a higher one occurs about the time of ovulation.

SPINAL ANESTHESIA FOR CESAREAN SECTION*

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The problem of the anesthesia to be employed in patients who are to have a cesarean section has always presented a number of difficulties. The fact that there are two patients to be considered in place of one makes the choice of the anesthetic of double importance. Inhalation anesthesia of some type has been the method most commonly used in this part of the state, and has included all the common agents, alone and in various combinations—nitrous oxide, ethylene, cyclopropane and ether. Where the operation is an elective one, when the patient can be properly prepared and when there is no co-existing pathological condition, one or another of these inhalation anesthetics gives a perfectly satisfactory anesthesia from the standpoint of patient, surgeon and anesthetist. However, there are certain conditions in which an inhalation anesthetic may not be satisfactory. I will enumerate some of these.

1. The patient who comes in as an emergency often has recently eaten a hearty meal. Every anesthetist knows the danger of giving a general anesthetic to a patient who has a full stomach.

2. The patient may have an acute upper respiratory infection, such as a severe cold, sinusitis, or bronchitis.

3. There may be some chronic or systemic disease, such as active pulmonary tuberculosis, toxemia of pregnancy, or diabetes. In the last two instances the anesthetist would hesitate to use inhalation anesthesia.

Added to the above considerations is the fact that most obstetricians refrain from giving any pre-anesthetic narcotic, so as not to depress the respiration of the baby. Then truly we have an anesthetic which is far from satisfactory. The patient often becomes more or less cyanotic. The surgeon complains of inadequate relaxation, and the anesthetist finds it impossible to maintain a smooth, quiet anesthetic level.

Our success in the use of spinal anesthesia for abdominal surgery suggested the possibility of using spinal for cesarean sections. Then one day we were confronted with the problem of cesarean section in a twenty-six-year-old girl who had active pulmonary tuberculosis with collapse of the right lung. It was decided to use spinal anesthesia for this section. She was given a combination of novocain 50 mgm. and pontocaine 10 mgm. in the second lumbar interspace. The anesthesia was entirely satisfactory, the operation lasted sixty-five minutes, the uterus contracted firmly as soon as the placenta was removed, and the baby cried spon-

taneously and vigorously immediately upon delivery. The patient made an uneventful recovery.

The point about which we had the most hesitation was the contraction of the uterus. The abdominal muscles are completely relaxed during spinal anesthesia. Would the uterine muscle share in this relaxation, or would the uterus contract normally after the delivery of the fetus?

Batten¹ reported a series of ninety-six sections in which spinal anesthesia was used. In all of these there was good tone of the uterine musculature and consequent minimal blood loss from the uterine incision. Eades² and Cosgrove³ reported similar experiences.

On the basis of experiments on pregnant rabbits, Ducuring⁴ concluded that the human pregnant uterus behaves under spinal anesthesia as does the pregnant uterus in rabbits after complete section of the lumbar region of the cord. This means that uterine contractions must be due to inherent rhythmic contractions and are not due to an intact nerve supply.

The innervation of the uterus is not well understood. The motor supply is known to be autonomic and involves both sympathetic and parasympathic components. Clinical evidence indicates that the motor fibers to the uterus leave the spinal cord at higher levels than the tenth thoracic nerve, whence they pass through the aortic, hypogastric, and pelvic plexuses.

DeLee⁵ states that there are independent nerve centers in the uterus, because the organ and small excisions act even when removed from the body, and perhaps there are nervous and muscular bundles similar to those in the heart.

The results in the series of cases here reported coincided with the experience of these authors. In each case the uterus contracted promptly after the baby was delivered, and by the time the operation was completed, it was firm and hard. This was true even when the level of anesthesia extended as high as the nipple line. The bleeding from the uterus was very slight. This conservation of blood is a distinct advantage to the mother.

The other consideration which was of special interest was the effect on the baby. Heard⁶ reported

¹ Batten, D. H.: Spinal Anesthesia in Cesarean Section, *Cur. Resear. Anes. and Anal.*, 20:2, 115 (March-April) 1941.

² Eades, M. F.: Observations on the Use of Spinal Anesthesia in Abdominal Obstetric Operations, *Am. Jour. Obs. Gyn.*, 23:407, 1932.

³ Cosgrove, S. A.: Spinal Anesthesia in Obstetrics, *Am. Jour. Surg.*, 5:602, 1928.

⁴ Ducuring, J.: *Bull. Soc. d' obst. et de gynec.*, 18:115, 1929.

⁵ DeLee, Joseph B.: *The Principles and Practice of Obstetrics*, 7th Edition, Chap. IV, p. 83.

* Presented before the Section on Anesthesia of the Indiana State Medical Association, at Indianapolis, September 29, 1943.

a series of sections under various types of anesthesia and made a number of interesting observations. He found that ether alone, or added to nitrous oxide or cyclopropane, is very definitely depressing to the fetus. In spinal anesthesia he found that most of the babies breathed before the feet were out of the incision, and cried lustily before the cord was cut. The difference, he says, between the baby born with spinal and the one with ether must be seen to be appreciated. Even with cyclopropane, he says, the baby does not approach, in rapidity of response, the one with spinal.

In our series, except for the case in which there was a macerated fetus, all babies cried immediately and there was no resuscitation problem.

The first mothers in our series received no pre-anesthetic narcotic, the morphine being withheld until after the delivery of the baby. A slightly different procedure was carried out in the last four cases. Each of these received morphine gr. 1/6, scopolamine gr. 1/150 one hour before operation. These patients received oxygen inhalations from the beginning of the operation up to the time of delivery. The babies all cried immediately on delivery. It is a distinct advantage to the mother to receive preoperative sedation, and if this can be given without harm to the baby it should not be withheld. Eades² reports that he gives morphine and scopolamine before his sections with no unfavorable results to mother or child. The number of our cases in which preoperative morphine was used is small, but the results coincide with those of Batten⁷, who reported twenty-five cases where morphine and scopolamine were administered before spinal anesthesia, and where the babies all cried immediately on delivery. Batten's article is of further interest in that he made studies of the oxygen content of the blood of the baby, and found that the oxygen content was higher when the mothers received spinal than when they received inhalation anesthetics. He found that the oxygen content of the baby's blood was still higher when oxygen was given to the mother continuously from the beginning of the operation until the time of delivery of the baby.

The series presented consists of fourteen sections done under spinal anesthesia, nine at the Indianapolis City Hospital and five at the Coleman Hospital. In one case the spinal anesthesia was of insufficient length and was supplemented with sodium pentothal. Four patients were given morphine and scopolamine preoperatively, eight received barbiturates, and two had no preoperative medication. In all cases, except the macerated fetus, the babies cried spontaneously. In all cases the uterus contracted promptly after delivery and uterine bleeding was minimal. There were no maternal deaths.

The only infant death was the premature stillborn mentioned above.

The advantages of spinal anesthesia hold true for the operation of cesarean section as much as for other abdominal surgery. Among these may be mentioned the better abdominal relaxation and the contracted intestines. The gut never forces itself up into the incision, as it often does under light inhalation anesthesia. Other points of advantage are the diminished blood loss, the fact that there is no disturbance of existing pathology of the circulatory, respiratory or genito-urinary systems of the mother, and the absence of nausea and vomiting, so that the mother may take fluids by mouth and resume her normal diet sooner.

SUMMARY

Study of a small series of cesarean sections done under spinal anesthesia brings out the following facts:

1. That spinal anesthesia is suitable for the operation of cesarean section.
2. That it does not interfere with the contraction of the uterus.
3. That the babies cry promptly and vigorously.
4. That the mothers may have the advantage of preoperative narcotics.

The results of the study demonstrate that in cases where inhalation anesthetics are contraindicated, spinal anesthesia is a safe and satisfactory substitute.

DISCUSSION

FRED A. THOMAS, M.D. (Indianapolis): Some years ago a wave of spinal anesthesia spread over the world. Today, due to safe drugs and safe technic of spinal puncture, we have a new wave of spinal anesthesia, and I am sure it is here to stay. I hope so because during this war it has been a god-send to the anesthetist. The Army and Navy have proved the relative safety of spinal anesthesia because a great number of cases have been done with spinal. I do not want to leave the impression that spinal anesthesia is without danger. We still have nausea and vomiting, which can be taken care of postoperatively by oxygen inhalations. Also we will have the bugbear of backache and headache, but with the skill we have attained the trauma is not great and backache is pretty well lessened. We do have an occasional patient who collapses and becomes unconscious, and sometimes succumbs.

As to my experience with cesarean section under spinal, the series is not very large. I have not used morphine with any of these cases. I heartily agree with Doctor Mueller that it is not suitable for certain cases. I would also say that the uterus contracts rapidly and the baby is usually in good condition. There are, however, certain cases of cesarean section which I think should not have spinal anesthesia. Those are the ones in acute shock or in intermediate shock, those who have had recent severe hemorrhage and those who have had

⁶ Heard, K. M.: Anesthesia in Cesarean Section, *Surg., Gyn. and Obs.*, 70:657, 1940.

⁷ Batten, D. H.: Cesarean Section under Spinal Anesthesia, *Curr. Resear. Anes. and Anal.*, 22:3, 143 (May-June) 1943.

septicemia. There is danger of implanting infection into the cord or brain of the infant. It has been brought out that pulmonary tuberculosis is a contraindication to spinal anesthesia in the same way as septicemia. That, of course, is a matter of personal opinion. Taking it all in all, I think that spinal anesthesia in many cases is a good substitute for general anesthesia.

GROVER L. VERPLANK, M.D. (Gary): It has been my experience that it does not make a great deal of difference whether it is ether or spinal as far as the cry of the baby is concerned, but it does make a difference what medication is used before giving the anesthetic. I think anyone will agree that the giving of a quarter grain of morphine before spinal anesthesia will make a great deal of difference in the response of the baby.

JOHN F. KELLY, M.D. (Indianapolis): I have been interested in this series of Dr. Mueller's for three years because I have always been interested in local anesthesia in obstetrics. She has given spinal to six private cases for me. The impression you have of it is a good deal like the impression that you get with continuous caudal—when it works well it is marvelous. In this small series at the City Hospital we have had no trouble at all with shock or collapse from spinal. It has a great advantage over infiltration local, of which I have done a great deal more over a period of many years in obstetrics, for it gives real anesthesia and anesthetizes the peritoneum, which infiltration local does not do. Infiltration local has been advocated by the Chicago Lying-in group for years, Doctor DeLee having done a great many cesareans under infiltration local, but they stay away from spinal. I do not believe that there is anyone here to take me up on that because I have not looked up the literature, but the general opinion of the group is that spinal is dangerous in obstetrics.

I want to say that with a woman who has been in labor and has had backache and is uncomfortable, if you have any reason to use spinal, within a few seconds after the drug is injected she is perfectly comfortable and you do the cesarean section

with no pain whatever. I have watched continuous caudal at the Coleman Hospital in this city, and have seen it used in two or three cesarean sections. You have to wait, as far as I know, one and one-half hours for continuous caudal to take hold and give anesthesia, whereas with spinal you do not have to wait. It is very efficacious and very pleasing to everyone around. So far I see no reason to use continuous caudal at all for cesarean section when you have spinal, unless there is danger in spinal. Spinal is much easier to give, technically, than an injection into the caudal opening.

About morphine, I believe Doctor Mueller said they used it on a private case of mine, and in most of the sections for which I scrubbed while on the City Hospital service. I leave it up to her. In the cases I did, the baby cried immediately. It scared me to death when she told me afterward that she had used morphine, but the baby cried at once. In all the City Hospital cases the babies cried immediately. This was new to me as I had believed that morphine depressed respiration in the baby. The residents who have scrubbed with me on sections were immediately impressed with the fact that the abdomen lay wide open and no retraction was necessary with spinal. I have had the anesthesia wear off in fifty minutes, but the section is usually completed in that time, so there is no difficulty.

CHARLES N. COMBS, M.D. (Terre Haute): The comparatively recent vogue of low cervical section, as compared with the old classical, has prompted me to use spinal more in late years because of the lighter dosage required and the increased margin of safety. I do not use morphine preoperatively at all, and yet my records show that the interval of time between delivery and the time the baby cries is decidedly shorter after spinal than after inhalation or intravenous anesthesia.

DOCTOR MUELLER (closing): I realize that this is a very small series and it does not really prove anything. I could not hope to prove much with fourteen or fifteen cases, but it has been so successful and so pleasing that I feel encouraged to go ahead and use it more freely than I have in the past.

ABSTRACT: PRESCRIPTION FOR HEAVY CREAM

Pointing out that the limitation of food supplies, particularly fats such as those contained in heavy cream, is intimately related to the progress of the war, *The Journal of the American Medical Association* for February 19 suggests that officials of the War Food Administration might well require that prescription by a physician for cream of a butterfat content greater than 19 per cent, for any of his patients definitely indicate the condition for which the prescription is written and that it be endorsed either by such an official as a county health officer or the secretary of the county medical society. "Physicians should welcome such restrictions, since a part of the responsibility and burden of the physician will then be shared by some other person in authority."

The War Food Administration has issued regulations prohibiting the use of cream with a butter fat content

higher than 19 per cent, except by sick persons on prescription by a physician or establishments for the care and treatment of the sick, on a statement from a physician who is an official of that institution.

"Unfortunately," *The Journal* says, "these regulations have not served to restrict suitably the prescription of cream of high fat content. The available evidence indicates, for instance, that the equivalent of half a million quarts a day is reported going into heavy cream on doctors' prescription in New York City."

As *The Journal* explains, the Council on Foods and Nutrition of the American Medical Association has said that the need for a milk product with more than 19 per cent butterfat content is practically limited to diets for certain cases of epilepsy.

SPECIFIC VACCINE THERAPY OF CHRONIC BRUCELLOSIS

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The basis of this report is the analysis of one hundred consecutive cases of chronic brucellosis which have been treated with various brucella vaccines and filtrates. (Two hundred additional cases have subsequently confirmed the observations of this study.) The criteria for diagnosis in these cases has been reported in previous papers.^{1, 2} The duration of treatment has varied from a few months to five years. None of these cases has been observed a sufficient number of years to be certain that there will be no relapses; none of them is called "cured." However, they have all been treated a sufficient number of months or years to provide a definite impression of the effect of treatment.

Aside from the statistical and subjective results of treatment, certain phenomena have occurred and certain observations have been made which are worth reporting. This is especially true since the recognition of the widespread incidence of chronic brucella infection is a development of only the present day, and the demand for treatment is developing faster than it can properly be met.

Unfortunate experience will have to be admitted, but without shame, for there has been no adequate guide to the safe and effective use of brucella vaccine in all cases. In spite of considerable literature^{3, 4, 5, 6, 7, 8, 9} reporting good results of vaccine therapy, it is well known that many physicians have given it up after a few or many trials in chronic cases. Carpenter and Boak¹⁰ reviewed the literature on therapy of brucellosis in 1936 and concluded (rather surprisingly) that it was not justifiable to attribute favorable results to the specific effect of

vaccines. There is a widespread impression that there is no really good treatment for this disease and that the victims are doomed to be chronically ill most of the time in spite of vitamins, tonics, liver extract, non-specific shock or fever therapy, and even specific vaccine itself. There must be some reason for these discrepancies in experience.

The evolution of vaccine therapy in connection with these one hundred cases can best be described in four periods of development. Like all periods of growth, they blended into one another but in retrospect are fairly distinct.

EARLY EXPERIENCE

The first or beginning period started in 1937. It was marked by the attempt to jolt the patient into resisting the disease by producing local and general reactions to killed brucella bacteria. This was done in the usual manner by injecting them by the millions into areas which were supposedly not engaged in fighting the infection, such as the subcutaneous tissues and muscles. A brief resumé of my first case will serve as an illustration.

Case 1. Miss D. W., aged twenty-eight, had her college education prolonged for ten years because of constantly-recurring illness. The diagnosis was made in 1937 on the basis of her course, symptoms, fever, negative physical findings, and a positive intradermal test. Treatment was begun by using .06 cc. of commercial *Brucella abortus* and suis vaccine hypodermically instead of .25 cc. as usually advised. She responded immediately with a marked improvement in her energy and general feelings. The dose was raised rapidly every few days in spite of some general reactions. The maximum dose, 2 billion bacteria, was given five times in twelve days toward the end of her second month of treatment, and the patient felt definitely improved. However, within three weeks after stopping treatment she was worse again, with severe hyperhidrosis and ease of fatigue in spite of a very high opsonocytaphagic index.^{8, 11, 12, 13} Stronger vaccine of another brand and larger doses were given with equivocal results. The patient seemed to feel better some of the time, but fever, fatigue, perspiration, and cold symptoms persisted. Local indurations at injection sites persisted for nearly a week. Doses as high as 1,000 billion bacteria were given in this second series.

After three months of travel and rest without vaccine she returned to college in better health than she had had for over ten years. But within the next month a relapse set in. This time she was given a course of brucellin (Huddleson's mixed bacterial free filtrate made from *Brucella abortus*, suis, and *melitensis*), to which she was

¹ Griggs, J. F.: Criteria For Diagnosis of Brucellosis, *Northwest Med.*, **41**:389-392, (Nov.) 1942.

² Griggs, J. F.: Chronic Brucellosis: Diagnostic Points Noted in 100 Cases, *Calif. & Western Med.*, **58**:118-124, (March) 1943.

³ Hagebusch, O. E., and Frei, C. F.: Undulant fever in Children, *Am. J. Clin. Path.*, **11**:497-515, (June) 1941.

⁴ Urschel, D. L.: Intradermal Vaccine Therapy in Brucellosis, *J. Ind. State Med. Assoc.*, **36**:385-389, (Aug.) 1943.

⁵ Harris, H. J.: Undulant Fever—Difficulties in Diagnosis and Treatment, *New York State J. Med.*, **34**:1017, (Dec. 1,) 1934.

⁶ Angle, F. E.: Treatment of Acute and Chronic Brucellosis (Undulant Fever), *J.A.M.A.*, **105**:939, (Sept. 21,) 1935.

⁷ Calder, R. M.: Chronic Brucellosis, *South. M. J.*, **32**:451-460, (May) 1939.

⁸ Harris, H. J.: Brucellosis (Undulant Fever) *Clinical and Subclinical*, Paul B. Hoeber, Inc., (April) 1941.

⁹ Simpson, W. M.: New Developments in Diagnosis and Treatment of Brucellosis (Undulant Fever), *Minnesota Med.*, **24**:725-738, (Sept.) 1941.

¹⁰ Carpenter, C. M., and Boak, R.: The Treatment of Human Brucellosis: A Review of Current Therapeutic Methods, *Medicine*, **15**:103-107, 1936.

¹¹ Foshay, L., and LeBlanc, T. J.: Derivation of Index Number for Opsonocytaphagic Test, *J. Lab. & Clin. Med.*, **22**:1297-1300, (Sept.) 1937.

¹² Calder, R. M.: Modification of Huddleson's Opsonocytaphagic Reaction, *J. Lab. & Clin. Med.*, **25**:769, (April) 1940.

¹³ Huddleson, I. F.; Johnson, H. W., and Hamann, E. E.: A Study of the Opsonocytaphagic Power of the Blood and Allergic Skin Reaction in Brucella Infection and Immunity in Man, *Am. J. Pub. Health*, **23**:917, 1933.

not very skin sensitive. She failed to shock, but did have epistaxis. She became neither better nor worse, but she stayed in school.

For the next six months vaccine was abandoned and the patient was given endocrine therapy and psychotherapy. Her condition remained stationary. Vaccine was resumed for three weeks at the end of the college year, the second year of treatment. The patient now remained quite well and active for two years in college and during her post-graduate work without any further treatment. A relapse then occurred.

ONLY 60 PER CENT SATISFACTORY RESULTS

At least twenty-eight more patients were treated by the above method. Only about 25 per cent "recovered" promptly. The disease continued in the remaining 75 per cent, of whom a little more than half were unquestionably improved. Results, then, might be considered somewhat satisfactory in nearly two-thirds of cases treated by this method.

THE IMPORTANCE OF SENSITIVITY

The next development was marked by the recognition of the extreme degree of sensitivity which is often developed to brucella vaccine, and by the realization that sensitivity increases following any tissue necrosis caused by specific brucella substances.

An esteemed colleague (*Case 5*) was gradually disabled by chronic brucellosis, and after he diagnosed his own case he was given three doses of commercial vaccine, as suggested in the leaflet accompanying the package. His general reactions were severe. He was helplessly confined to bed for the next seven months. The exacerbation of his disease was obvious although his fever never rose much above 100°. There were evidences of a mild encephalitis and his generalized stiffness and soreness made every move painful. As to his local reactions, during the following six months all three injected areas successively broke down into sterile abscesses of liquefaction necrosis. Meanwhile, an attempt was being made to desensitize and immunize the patient by the use of diluted doses of an oxidized *Brucella abortus* and suis vaccine.^{14, 15} This vaccine caused no necrosis, but it had to be progressively diluted because of severe and persistent general and local reactions. Even doses in the 1:2000 dilution could not be tolerated. During two of the months in bed the patient was given no vaccine but a great variety of non-specific supportive measures: diathermy, tonics, vitamins, and liver extract. Only the liver extract seemed to be of any value, and even that was slight. Sulfonamides were not tolerated. Intravenous desensitization was then attempted. The first dose was the amount of specific substance theoretically present in four bacteria, using the oxidized vaccine. After several injections it became obvious that the patient's sensitivity was increasing instead of decreasing, and this continued regardless of the size of the dose. Vaccine therapy was abandoned. After one year of disability the patient resumed his practice, but his real improvement came only after the last sterile necrosis had entirely healed. He has never regained his former health.

Coincident with this experience there were eleven other cases who received 4-plus reactions with necrosis of the skin from intradermal injections of brucellergen or vaccine for diagnosis. In addition

there were fourteen more cases in which necrosis threatened but was confined to a premature dry desquamation of epidermis over a 4-plus reaction, or was evident as a delayed healing of the hypodermic needle tract. All of these twenty-five patients very obviously have the disease, and all of them proved to be very difficult therapeutic problems by any method of treatment. They were particularly intolerant of vaccine in any doses that have ever been recommended. A few of them thought that the unpleasant encounter with vaccine had benefited their general condition nevertheless. The experience with these twenty-five cases of local tissue hypersensitivity constituted the period of a rude awakening to the allergenic power of brucella substances and the significance of local tissue intolerance.

EXPERIENCE WITH PROGRESSIVE DILUTIONS

The third period was one of experimentation in an attempt to find out: (1) how small the dose of brucella substance must be made in order to be tolerated by hypersensitive patients; (2) whether these patients can be desensitized; and (3) whether reactions of hypersensitivity can be avoided.

The vaccine was progressively diluted 1:20, 1:100, 1:500, 1:1000 and 1:2000. Each weaker dilution looked more hopeful than the former, but each was intolerable when given more than once to a patient who had had a local tissue necrosis. It was evident that each injection increased the patient's sensitivity whenever there was delayed healing of the needle tract or a persistent nodular induration resulting from the injection. Time was allowed to pass while all evidence of previous injections healed; then vaccine was begun again in still weaker dilutions. Under these circumstances it was surprising to find that patients who had had necrosis could not tolerate hypodermic injections of even a fraction of 1 brucella bacterium for more than a few doses. By perseverance in diluting the vaccine it was found that some of these patients can tolerate doses which represent the amount of specific substance theoretically present in 0.00002 of 1 bacterium if an oxidized vaccine¹⁵ is used. Local reactions always occurred, and often general reactions also occurred, so that we were assured of the actual presence of an appreciable amount of *Brucella* antigen in such a dose. (These doses are not as ridiculously small as they appear. The size of the protein molecules is such that specific proteins are present in doses as small as .00000000000001 of 1 bacterium—or 1 bacterium $\times 10^{-14}$ —according to modern theory in physical chemistry. Some specific brucella substances are polysaccharides, much smaller molecules than proteins,^{16, 17} so that still further dilutions actually contain biologically appreciable doses of specific brucella antigen or allergen.) From this

¹⁴ O'Neil, A. E.: Preliminary Note on the Treatment of Undulant Fever in Man with Detoxified Vaccine and with Antiserum, *Ohio State M. J.*, **29**:438, 1933.

¹⁵ Foshay, L.; Hesselbrock, W. H.; Wittenberg, H. J., and Rodenberg, A. H.: Vaccine Prophylaxis Against Tularemia in Man, *Am. J. Pub. Health*, **32**:1131-1145, (Oct.) 1942.

¹⁶ Heidelberger, M., and Goebel, W. F.: The Soluble Specific Substance of *Pneumococcus*, *J. Biol. Chem.*, **70**:614, 1926 and **74**:613, 1927.

point the doses could be doubled every three or four days. After three to twelve of these extremely minute doses the patient's sensitivity seemed to decrease. Local and general reactions failed to appear for the most part, and at the same time real clinical improvement began to appear coincident with desensitization. However, there have been some patients so sensitive that they have not tolerated even 0.0000004 of 1 bacterium, and we have not yet found a dose small enough for some of them.

An effort was made to desensitize some hypersensitive patients by intravenous vaccination, as advocated by Harris.⁸ The initial doses ranged from 0.0000004 of 1 bacterium to a few million bacteria. In only a few cases was this successful. In these cases necrotic areas had completed their final stages of healing before desensitization was attempted. The difficulty was that the hypersensitive cases generally continued to become more and more sensitized. The doses had to be decreased instead of increased in order to avoid successively more severe general reactions and persisting exacerbations. However, the intravenous route became valuable to a small, important group of cases after we learned the necessity of still smaller initial doses.

The work of Urschel⁴ and House suggests that the intradermal route may be as effective in immunizing against brucellosis as it is in other conditions. Urschel says that it can be used without increasing sensitivity. This is worthy of further investigation. Theoretically, the stretching of the skin and the slow absorption offer some objections, but from the practical viewpoint there are advantages in the ease of observation and the decreased frequency of injections. We have recently begun a series of patients on this method, but it is too early to draw conclusions.

THE PROBLEM OF HYPERSENSITIVITY

The first step in preventing hypersensitivity from appearing was to alter the strength of the skin-testing material. Skin necrosis occurred in 10 per cent of the patients in whom vaccine was used for skin testing, even when the vaccine was diluted according to directions. Brucellergen, being a protein nucleate and milder, was adopted for initial skin tests. As supplied in 1:12,000 dilution, brucellergen caused necrosis in seven cases and near-necrosis in four cases, so it was diluted to 1:48,000. This dilution caused skin necrosis in one case and near-necrosis in two cases. A further dilution to 1:120,000 caused near-necrosis in three cases but has not yet caused a necrosis of any of the vascular layers of the skin. This dilution has been adopted for initial skin tests. It is perfectly clear that persons who get a near-necrosis from this dilution would get a real necrosis from a

stronger dilution of brucellergen or from vaccine; then their sensitivity would be increased. If initial skin tests with brucellergen in increasing strengths are negative, heat-killed vaccine may be used intradermally as a final diagnostic check. Urschel⁴ and Keller¹⁸ have also studied skin-testing materials quantitatively.

The second step in preventing hypersensitivity has been to start all new patients on the very minute desensitizing doses of Foshay's oxidized brucella vaccine.¹⁵ The third step has been to change most patients over from commercial vaccine to oxidized vaccine. Both of these measures have yielded very gratifying results in preventing and overcoming hypersensitivity. It is not yet possible to prove which of the two is more responsible for the success because both have been done together. The change to oxidized vaccine has been made without desensitizing, but desensitizing by the infinitesimal doses has not been attempted with commercial vaccine. (This has subsequently been done successfully by A. V. Stoughton, M.D., of Claremont, California.)

It was surprising to find that (1) many patients, even though not giving excessive skin tests, showed local reactions from their first few doses of vaccine diluted to the amount of specific substance represented by 0.00004 of 1 bacterium; and (2) that improvement was often noted during desensitization before immunizing doses had been reached. This was particularly true in patients having a high sensitivity. Some with a low sensitivity have not had any local reactions to doses smaller than 1 bacterium and have noticed no improvement until much larger doses have been reached.

TREATMENT OF STUBBORN CASES

The latest period has been concerned with those patients who do fairly well on vaccine for a few months and then reach a plateau beyond which they cannot progress. They are not the ones with an increased skin sensitivity. Their reactions are not excessive, but they often say they cannot tell whether their "down days" are due to the injections or to the natural undulations of the disease. It was observed that several of these patients progressed a little better when changed over to the oxidized vaccine. It was not so much that they tolerated bigger increases in dosage as that they felt better on their usual doses when oxidized vaccine was used. It was also observed that when a shortage of oxidized vaccine caused the substitution of commercial vaccine for it, many of the patients had exacerbations of symptoms. It was decided to desensitize some of these "plateau" patients in spite of the fact that they had no obvious hypersensitivity of their skin and subcutaneous tissues. This has not been done long

¹⁷ Avery, O. T., and Heidelberger, M.: Immunological Relationships of Cell Constituents of Pneumococcus, *J. Exp. Med.*, **38**:85, 1923.

¹⁸ Keller, A. E.: Comparison of Skin Reactions Obtained by Use of Brucellergen and of Heated Brucella Organisms in Sensitized Individuals, *South. Med. J.*, **33**:1180-1184, (Nov.) 1940.

enough to know what its long-term results will be, but its results to date have been very encouraging. One case will serve as an illustration for about twenty.

Case 15. Mrs. V. S., aged forty-nine, after four years of severe neuritis, myalgia and a great variety of organic and functional disorders, had been diagnosed chronic brucellosis elsewhere on the basis of history, lymphocytosis, and a 3-plus intradermal reaction to brucellergen without necrosis. She was treated with a commercial vaccine every two or three days, starting with 100,000 killed bacteria and increasing slowly to 2 billion within a period of eight weeks. Her tissues tolerated these doses with only transient soreness, but her symptoms and general condition remained unchanged: sometimes a little better, more often worse. After one month of estrogens only, she was still feeling only very slightly better. At this time she had a useless and practically immoveable right shoulder and arm because of severe neuralgia and myalgia requiring codeine. A desensitizing series of oxidized vaccine was begun, starting with the amount of brucella substance theoretically present in .00004 of 1 brucella bacterium, and increasing each dose by 10x every one to three days. To the first three doses she reacted locally with very slight pinkness around the needle tract, and the minutest superficial induration of the skin. Thereafter there were no reactions. She immediately began to sleep through the nights and in one week omitted her sedatives. Within two weeks she had much more energy and was using her lame arm enough to get blisters on her hand from working. Improvement was fairly steady, except when she tired herself out by too much unaccustomed activity. Within seven weeks she could fully extend her right elbow, put her hand back of her neck or eat with this hand. The shoulder could now be set back into the normal position of good posture, and she was taking full care of a sixteen-pound baby. She said she was doing "100 per cent more work" than she could possibly have done for many months. Digestive troubles were all gone. Within two months she said she was "150 per cent better." Her dose of oxidized vaccine at this time was 20 million bacteria and there was no local reaction.

This latter case illustrates the improvement which may be obtained by desensitization even in a patient who does not appear to have local tissue sensitivity in the areas injected. It also suggests that sensitivity may be the reason for the failure of the larger doses of vaccine used earlier.

RESULTS OF VACCINE THERAPY

The present period of development, then, is the period of alternate desensitization and immunization. This method of using vaccine has certain strong theoretical recommendations which could be elaborated at length. (cf. The extreme dilutions necessary to make tuberculin safe and effective when it is indicated in the treatment of tuberculosis. Note also that chronic brucellosis often resembles an allergy more than an active infection.) However, the important consideration is the practical one of therapeutic results. An analysis of the present status of one hundred cases, most of them still under treatment, is given below. It includes cases representative of all four periods of vaccine therapy described above. The descriptive terms used are regrettably inexact and are explained as follows:

"Poor" means that the treatment was consistently or finally disadvantageous.

"Unimproved" means neither better nor worse, finally. During treatment several of these cases were alternately much better and worse. These are all hypersensitive patients and are the ones in whom ordinary doses of vaccine seem to "bring out the disease" temporarily.

"Fair" means definite subjective or objective improvement, but no complete relief from symptoms for longer periods than the natural course of the disease manifested for that individual.

"Good" means "better in every way" or "better than I have been for years" or "30 to 80 per cent improved."

"Very good" means marked improvement, or loss of disability, or relatively long remission from symptoms. Sometimes it means a spectacular relief from long suffering without complete return of constant health and strength; "80 to 200 per cent better."

"Excellent" means apparently recovered for a sufficient number of months and with sufficient speed to suggest that a permanent remission may be possible.

The results of all vaccine therapy have been as follows:

Results	Cases
Poor	2
Unimproved	8
Fair	10
Good	38
Very good	26
Excellent	16
Total	100
	Cases
Total improved	90
Total hypersensitive	25
Hypersensitive cases improved	17
Hypersensitive cases unimproved	8

Our present scheme of vaccine therapy embraces the following principles:

1. Avoid any degree of necrosis or delayed absorption of vaccine by using minute doses of very dilute, detoxified vaccine¹⁵ and initial skin-testing materials (brucellergen 1:120,000).

2. Desensitize before (or after) attempting to immunize.

3. Avoid giving more vaccine while local reactions are still present. Local reaction should disappear within one to three days. After five days without vaccine, sensitivity is likely to increase again.

4. Avoid general reactions except of the mildest sort.

5. If a patient has a necrotic skin test or persistent nodular induration from vaccines, or proves to become more sensitive instead of less, give no more vaccine until the tissues are entirely healed,

smooth and soft. Meanwhile, give liver extract or suprarenal cortex intramuscularly, alternating with Vitamin B complex and cacodylates intravenously, then desensitize.

6. If the most minute doses of vaccine are not tolerated intramuscularly, intradermal or intravenous desensitization may be resorted to if the patient's condition warrants it.

7. If a patient is clinically not recovered after maintaining high opsonic powers^{8, 11, 12, 13} for several months, eliminate foci and desensitize again even though the patient is not skin sensitive. Alternately immunize and desensitize repeatedly.

SUMMARY

1. The story of the specific vaccine therapy of one hundred consecutive cases of chronic brucellosis is reviewed.

2. The usual forms of brucella vaccine therapy were complicated by the appearance of hypersensitivity in at least 25 per cent of our first cases.

3. The increase in hypersensitivity which is caused by tissue necrosis was studied quantitatively.

4. It was found that increasing hypersensitivity can be avoided, and that desensitization is frequently possible if sufficiently minute doses of oxidized brucella vaccine are used (much less than 1 bacterium at first).

5. Clinical improvement follows desensitization, even in stubborn cases which are not very skin sensitive. Desensitization and immunization have given encouraging results when done alternately and repeatedly in the same patient. Good results, or better, have followed the various methods of specific vaccine therapy in 80 per cent of our cases. Since adopting the improvements reported in this paper, good results have been obtained in 85 to 95 per cent of two hundred additional cases.

6. Final conclusions cannot be drawn until several years after treatment has been completed or continued in cases of chronic brucellosis.

ABSTRACT

URGE BLOOD STUDY FOR ALL WHO RETURN FROM MALARIOUS AREAS

The blood of all persons who have returned from areas where malaria is prevalent should be carefully examined and all those found to have in their blood the organisms that cause the disease should be treated even though they have no symptoms, Captain Stanis P. Carney, Sanitary Corps, and Captain Noah B. Levin, Medical Corps, Army of the United States, advise in *The Journal of the American Medical Association* for April 8. In an examination of 2,723 Italian prisoners of war who had seen service for varying periods in malarious regions, the two army officers found the organisms causing malaria still in the blood of some of the prisoners months after evacuation from a region where malaria was prevalent. They found parasites in the blood of men who had maintained they never had had the disease, and also that malaria may be contracted with no symptoms of active disease until months after infection.

It is emphasized by the authors that "No expectation of the residual malarial rate of United States troops can be predicated from these findings. A great many of the Italians grew up in malarious regions and were exposed and infected long before their period of military service, while only a relatively small percentage of American soldiers come from areas where malaria is present in any degree at all. The antimalaria precautions taken for United States troops in the field also serve to keep the incidence of malaria down. An advice from the office of the Surgeon General of the United States Army indicates that the incidence of parasitemia in the absence of clinical symptoms for our returned troops is much lower than the figures reported here for the prisoner group. In spite of these differential factors, we feel that this study emphasizes the necessity for careful examination

of blood smears for all personnel who have returned from areas where malaria is prevalent and the need for treatment to sterilize the blood in all cases of parasitemia. This will serve the double purpose of protecting the person from further attacks and of eliminating him as a carrier."

Of the 2,723 prisoners examined, 257 or 9.7 per cent had a positive blood smear; 56 or 2.1 per cent had active malaria; 188 or 6.5 per cent had a history of malaria; 33 or 59 per cent of those with active malaria had no history of malaria and 212 or 83 per cent of those with positive smears had no history of the disease.

The authors explain that it soon became apparent that malaria was going to be a problem of some concern in the prison camp "since immediately after arrival of the prisoners cases of malaria began to appear. The first question which arose was the problem of transmission of the disease to the uninfected prisoners, to the army personnel attached to the camp and to the nearby civilian population. This was satisfactorily answered by the results of two mosquito surveys made in the area in which the camp is located, one made by the state university and the other under the direction of the Seventh Service Command, in both of which no anopheline mosquitoes were found. As an added precaution, however, all men hospitalized for malaria were screened by mosquito bars after dusk.

"The proposal to send some of the prisoners to work on farms in the region of the camp raised another question. Since, in many cases, side camps were to be set up, sometimes many miles away from Army hospital facilities, it was decided to make an attempt to locate all men with parasitemia."



THE JOURNAL OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

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MAY, 1944

Editorials

CONSERVATION OF VISION

With this issue we are presenting the fifth annual Conservation of Vision Number of THE JOURNAL of the Indiana State Medical Association. Our Committee on Conservation has cooperated in the preparation of the papers in this and the previous similar issues of THE JOURNAL.

Our committee realizes that the members of the medical profession are being constantly deluged with information and technical material by many groups who are interested in some special phase of medical problems and practice. One's inclination is to respond to this excessive supply of literature by reading little or none of it. Without any desire to be melodramatic, we should like to call the attention of anyone who may be reading these words to the fact that without his gift of sight he would be unable to read them. Your Conservation of Vision Committee has been working for several years with a single purpose, namely, to aid in every way possible the preservation of the precious function of sight.

This number of THE JOURNAL contains several carefully-prepared papers which describe a few of the new developments and review some old and tried methods—all of which are directed toward a common goal, the prevention of blindness. We are hopeful that our readers may find time to study each one of these papers with interest in the new developments and with profit from reviewing the old and tried therapeutic methods.

POST-WAR THINKING

Just now the nation is engaged in war, and being so engaged is a bit too busy to give over to post-war planning; yet our press daily gives column after column to stories about this or that post-war plan, some of them chimerical, some of them apparently impossible to carry out, and a few that possess ideas that are worth thinking about.

Our political friends, those folk who live and have their being in matters political, are busy. They have their dreams, some of these dreams being a potential reality if we languidly sit by and let them come to pass.

Other organizations are approaching the period with a common-sense attitude. They well realize that post-war conditions will call for many changes in the program we have followed for years. It is to this group that we must look for guidance.

Medicine, too, will have its problems. With some fifty thousand or more of our men in the armed forces, their home-coming affords additional problems. Those of us at home will find it necessary to readjust our professional lives. We can not sit idly by and say, "Let's wait until the boys get back, then see what we can do about it." We must be forehanded in this; we must have more than a semblance of an idea of what it is all about—it is one of the *musts* that we have a program well worked out, and an elastic program it must be.

Many local societies long ago arranged that men leaving for the armed services, who had given up their appointments, should find these appointments awaiting them upon their return. Other groups have arranged that "family practice," in so far as possible, would be turned over to returning physicians. Other plans have been made and probably will be carried out, as they should be.

But there are other considerations. Through the years the practice of medicine is a changing thing. There are new developments in the study of the causation of disease; new discoveries in the therapeutic field are of almost daily occurrence, and many of the latter are the direct result of the experiences of our physicians engaged in actual fields of combat. Some of these returning men will be our teachers, and they will teach from actual field-experience.

New fields of medicine, rather fields that heretofore have occupied the attention of comparatively few physicians, will be opened up. We dare to predict that many of the textbooks on psychiatry, as we now know it, will be rewritten, for this is one phase of war medicine that has made huge strides in the past few years—all because of war experiences.

Air Medicine, as such, has come into its own, and will remain a most important phase of medical study for years to come. America is becoming air-minded, and ere the war has come to a close will be more and more air-minded.

Chemotherapy long since has passed the initial experimental stage, and while its discoveries are

but beginning, it even now is recognized as one of our most important sources of treatment. For example, the sulfa drugs were long in coming, even after their first discovery, but few practitioners have failed to adopt them as of this date. Again we predict that we have but scratched the surface of chemotherapy; who can say as to its future?

One of the lowly molds that for years did little more than pester the housewife now has become one of our greatest allies in infection control. Diseases of the type that all too often failed to respond to treatment now disappear like magic under the touch of penicillin. This same penicillin which is now almost impossible to obtain for private practice soon will be as easily procured as the antitoxins.

Veritably, we are but at the threshold of medical and surgical progress. And that reminds us of some statements made by Dr. John H. Oliver, forty odd years ago, when he was at the head of the Department of Surgery in our medical school. In speaking of modern surgical advancement, he remarked that no matter how striking some new operative procedure might appear, we were but at the threshold of surgical and medical progress.

One might devote columns in delineating what is ahead in medicine, but we, each of us, have our dreams, if they might be called that. Rather than do too much dreaming, however, let us do some acting. Let us ready ourselves for the things to come. This war will not last forever, and when the end finally comes we will find that we have a Herculean task before us — a task that will not be insurmountable, however, if we but make definite plans *now*.

So, let's get those plans ready; check and re-check, then again check to see that they are workable. Our fellows in service, scattered all over the face of the globe, have little time for planning. They are too busy with their current jobs; it is up to those of us at home to have workable plans ready for them when they return.

PHYSICIANS CAN HELP

In the field of preventive medicine a vital factor is an intimate acquaintance with the disease whose control is sought, and a most important part of such a program is in ascertaining just how prevalent the disease may be, and its habitat. Some diseases are found much more commonly in certain sections of the country; some are found in certain state areas, while others appear to be general.

A large number of these diseases are reportable, just for that reason; the health authorities must know where these infections are located, else they cannot lay out a successful plan of attack.

This specifically refers to the present campaign against tuberculosis, a disease with which we long have been familiar and had become rather complacent in the belief that its former ravages were

somewhat under control. However, induction center checks have shown that tuberculosis among our younger group is far more prevalent than had been suspected, which leads to the observation that we either have been overlooking these cases, or that we have not been reporting them.

The latter seems to be true — health authorities openly declare it to be so. A check was made of the deaths from tuberculosis within the state, for 1943, showing that 1,216 Indiana residents had died from this disease, *and that but 281 of the cases had officially been reported*. As stated in a down-state newspaper, this shows that the present reporting system is but 23 per cent efficient.

There is something wrong with such a system, and we do not feel that the health authorities can be blamed for the present situation; as a matter of fact, the fault lies with the medical profession — we are lax in making these reports.

We can understand the reluctance on the part of some physicians in reporting cases of venereal disease, but we fail to sense any real objection to the reporting of tuberculosis. Long, long ago a case of tuberculosis — then called "consumption" — was deemed by many families as a stigma; they kept that information from their neighbors as long as they could. But in these times, when everyone knows a lot about tuberculosis, when we have anti-tuberculosis societies in the majority of our counties — most of them doing a real job — Hoosier folk have a rather intimate knowledge of tuberculosis problems.

Most every community has one or more cases of tuberculosis which have been detected by the induction examinations. A lot of these cases never had presented themselves to the family physician for examination; hence, the blame in those cases cannot be laid at the door of the medical profession. But when a diagnosis of tuberculosis is made and the examiner fails to report his findings, then there is a real cause for censure.

The medical profession is moving hand and foot to place itself in a proper light before the people of the country; we are opening our records, that all may behold what has been done and what is being done to safeguard health; we are asking the support of all thinking people in our fight for self-preservation, and we cannot afford to overlook any detail that may lead to a poor impression.

World War II records, in the matter of tuberculosis, will be opened to the public one of these days, and it behooves us to see to it that the part we play is above reproach.

It does not take long to make out these reports, and their value is almost incalculable. Our health officials thus will be enabled to do a far better job in the matter of the prevention and the control of this disease. Each of us should make it a personal job, seeing to it that no stone is left unturned in the campaign against communicable disease.

THE SHELBY COUNTY PROGRAM

Many of our county medical groups are doing things in a big way these days. Some have taken very definite steps regarding the various economic problems presently confronting the medical profession; some have taken rather drastic steps to correct abuses within their own confines. (Witness the action of the Sullivan County group in the matter of elimination of political control of their local hospital, concerning which we will say more elsewhere in this issue.)

When the purport of the Wagner-Murray-Dingell Bill was fully understood, many Indiana society groups acted promptly, and at the last state convention the House of Delegates had for its consideration several resolutions, each couched in language that was quite understandable. A few societies within the state have taken to the public press as a means of expressing their views, several of them using paid advertisements to bring this about.

Among these active groups was one located in east central Indiana, a county commonly termed an agricultural area. Immediately prior to the war there was a total of twenty-six members in this county medical society. Nine of these enlisted in the armed forces, one of whom died in active service. The seventeen members remaining have been active; they have done things; and they have made it clear to the people of their community just where they stand in this campaign against the regimentation of the greatest of the professions.

These men are indeed fortunate in having as their representative on the Council of the Indiana State Medical Association a doctor who knows what it is all about and who makes no bones about saying what he thinks. He is a man well over the retiring age, but he has not sought the solace of retirement; he is not a rocking chair chap—he is alert.

We are speaking of the Shelby County (Indiana) Medical Society. We are talking about the things that a small group of doctors, so far as numbers go, are doing. They are busy men. Shelby County has a lot of road mileage; they do not have too many doctors to take care of the urban and rural population, yet things down there are well in hand, medically speaking.

These men have definite ideas about the Wagner-Murray-Dingell Bill and want their home folk to know about it; so they use the best means available to tell their story—a full-page advertisement in the *Shelbyville Democrat*, of Monday, March 27, 1944. In large type they headed the ad with a large sum of money, in fact, *over three billion dollars*. Three billion dollars is a lot of money in any man's country, and the mention of that amount is certain to attract the attention of thrifty Hoosiers who are accustomed to think of money in much smaller sums.

Then the ad goes on to say that the men speaking are the neighbors of the readers; they are fellow

members of the churches, lodges, et cetera; they are not an out-of-county group—folks who live right there are doing the talking.

Following this, in bold type, is the announcement that this bill would eliminate the personal relationship between the physician and the patient. It intimates rather strongly that the doctors might elect to work a matter of eight hours per day, as most other folk work these days. The lack of initiative which is sure to follow such a program is made quite clear to the reader; personal interest in the patient would lag; and the physicians probably would have to adopt treatment recommended by the "Big Boss."

Then the advertisement launches into a frank discussion of what it is all about. It admits that in some sections of the country there may be occasional instances of lack of proper medical care, but insists that political medicine is not the proper answer. It also cites the self-evident fact that in times of unemployment there will be several million people who cannot contribute 6 per cent of their wages to this Utopian fund, also reminding the reader that this always will be true of those who will not work.

The society approves of health and hospital insurance *on a voluntary basis*, and *under the supervision of the medical profession*, which is just where it belongs.

A statement that is most illuminating follows: "We further believe that community health problems, like *all other* community problems, can best be solved by the communities themselves, as opposed to control by bureaucrats. We have a much keener insight regarding our local affairs than any bureau in Washington. We believe in the true American way. Our forefathers fought for it, and now our sons, brothers and fathers are fighting for it."

About half of the page is given over to a group of to-the-point cartoons, and includes a brief summary of some of the outstanding achievements of the medical profession in the past one hundred fifty years. The whole setup is the most informative, the most convincing pronouncement we have yet seen, and written and published as it is by a group of men known to every person in Shelby County, it will carry much weight.

A full list of the members of the local society, including the physicians in service, is appended. Hats off to Shelby County!

Make your reservations now
for the
Annual Meeting of the
Indiana State Medical Association
on October 3, 4 and 5, 1944

MATERNITY AND INFANT-CARE PROGRAM

Dr. Harold M. Camp, secretary of the Illinois State Medical Society and editor of the *Illinois Medical Journal*, has addressed a letter to all state medical journals, enclosing an analysis of the Emergency Maternity and Infant-Care Program, by a member of that society. This analysis is comprehensive and indicates that the writer has canvassed every available bit of material on the subject. He starts at the beginning, when the Children's Bureau found themselves possessed of some unused funds and decided to use them. This they did in conjunction with the Washington State Health Department.

The first special appropriation was made as of March 8, 1943, in the sum of \$1,200,000. Later, almost four and one-half millions were added to this sum. Again, on October 1, 1943, the Congress appropriated \$18,600,000, with an added \$20,000 for administrative expense. This appropriation covered services to wives of men in the fourth to seventh pay grades.

While there was no opposition to this bill, some physicians felt that the money should be paid as a flat grant and directly to the recipient, rather than to the physician and the hospital rendering the care. An amendment was offered to this effect but was defeated on the floor of the House.

It is stated that Dr. Martha Eliot told the Senate subcommittee that the medical, maternity and child-health advisory committees were consulted in the matter of fees to be allowed, but that Dr. W. W. Bauer disagreed on this point, stating that all such policies rested with the Children's Bureau.

Miss Lenroot, also speaking before the Senate subcommittee, stated that the bureau had required that the physician certify that he will not make an additional charge for the care of the patient, declaring that a physician might accept the nominal fee from the bureau, but charge the mother an additional fee. At this point Senator Overton, of Louisiana, is quoted as having said, "This may be all right, but it certainly smacks of regimentation."

The writer then comments, "It would be interesting to know on what basis Miss Lenroot made a statement so wide of the truth. Over the country medical associations are saying that they will see that the wives of the men in the armed forces get good care, regardless of the Children's Bureau. The members of some medical societies prefer to render gratuitous care to the wives and infants of enlisted men rather than accept the dicta of the Children's Bureau."

Then the writer says, "The law sets no fee. The Children's Bureau does that. The law does not say that these women shall be treated in the same way as charity patients, or handled by the same facilities. The Children's Bureau sets up those regulations." He then brings out the very important point that *the law says the bureau shall approve state*

plans, but does not provide that the bureau shall write the plans!

Further, he states that the bureau was entrusted with the expenditure of an appropriation to which no one objected, but that the bureau employees have so managed or mismanaged the matter as to stir up argument, animosity and ill will in most states. He then cites many articles written by medical men of many sections of the country.

He quotes Dr. L. Fernald Foster, of Michigan, to the effect that many physicians question the sincerity of purpose of the program, and that it might be that this project is being used as a trial balloon for complete federalization of medical practice.

Dr. Walter L. Bierring, of Iowa, said it was difficult to understand the attitude of the bureau in determining the administrative plans without previous conference with the professional agencies responsible for rendering the service.

In Texas it was found that the directives of the bureau were in conflict with Texas state laws. In an editorial in the *Texas State Journal of Medicine* it was pointed out that in December, 1942, the Texas State Health Department had set up a plan which had been approved by the bureau, and that the plan had been put into operation. Eleven months later, November 27, 1943, a statement was credited to Dr. E. F. Daily, of the Children's Bureau, in a news release from Washington to a Fort Worth paper, that "The Plan in Texas is now about ready for approval, and for the first time wives of service men in Texas will be entitled to the financial aid authorized under the Maternity Care Program." (We choose to stick with Texas on this.)

It appears to us that Dr. Daily made still another blunder when he presented a plan whereby he added a "clinic section" to the law, providing that these women should go to free clinics, if they so desired. It is stated that Dr. Daily reacted to Illinois' opposition to this plan, to the extent that he once declared that if his "clinic section" was not adopted there would be no program in Illinois.

Another angle to the Illinois situation developed when the director of the Cook County Bureau of Public Welfare sought to have some of these women go to the Cook County Hospital. The catch in this is that while the law provides that women shall have a free choice of physician, the Cook County Hospital staff is of the closed variety; hence, there would be no free choice.

The writer again is quoted: "Dr. Daily and the Cook County Bureau of Public Welfare are apparently attempting to do two things: treat the soldiers' wives as charity patients and exploit the obstetrical staff of the county hospital by having

its members render free care to patients for whom a medical fee is provided."

Thus is sketched an article full of worth-while, thought-provoking material. The writer, his name unknown to us, apparently has spent hours in the compilation of his material. A bibliography is attached to the article, making it authentic. We should like personally to congratulate the writer for a notable contribution to an important subject.

Editorial Notes

An advance notice from a reputable pharmaceutical house advises that they believe they have found a new drug which is very efficacious in the treatment of tetanus, and that full information will be given to the medical profession in a short time.

Howard County seems to have gone in for a wholesale system of vaccinating against typhoid fever, following the recent epidemic in that section of the state. It is reported that over eight thousand persons have received these inoculations in the last few weeks.

A Rushville paper states that with the departure of another physician for the armed services, only eight active doctors will remain in that live community. Rush County has a population of about eighteen thousand, which brings the doctor-patient average rather low.

The state press continues to print matters pertaining to the attack made on the Wagner-Murray-Dingell Bill by the American Bar Association. This printed statement by the Association, by the way, is a most interesting document. It gives a complete resume of the features of the bill and points out the glaring errors in the pronouncements of those who favor such a measure.

We recently spent a few days at French Lick; occupying most of our time in "kibitzing" the training program of the Sox and Cubs. While there, Tom Taggart took occasion to remind us that it is quite some time ago since the state association held its meeting there, and that he would be very glad to play host to the group in the near future. We never have lost our liking for French Lick and trust that some day we may all get back there.

The infantile diarrhea problem is by no means solved, it is indicated by reports from some centers over the state. One local society has urged its members to report all cases to the local secretary, that steps may be taken to carry on an investigation which is under way at the present time.

Culinary note: The flat-lake herring, the salt fish we mentioned in a former number of *THE JOURNAL*, that was impounded by the OPA because of failure to set a price ceiling on same, still remain unavailable even though they were ready for the market last December. And it is to be remembered that age adds little to the enjoyment of eating such fish!

Dean Wilburt C. Davison, of Duke University School of Medicine, is quoted as having recommended in an address that we do some medical advertising. He states that he believes the American Medical Association, as well as other of the larger medical organizations, might do well to go in for an extensive advertising program. We are inclined to agree with the doctor. We as a profession have a lot of good things to tell the reading public, and properly-prepared and properly-controlled advertising would be a good idea, we opine.

Clarence A. Jackson, executive vice-president of the Indiana Chamber of Commerce, continues to hammer away at the Wagner-Murray-Dingell Bill. At a Noblesville meeting, sponsored by the Hamilton County Medical Society, a capacity crowd turned out to hear Mr. Jackson.

The public meeting at Terre Haute, featuring Dr. Morris Fishbein, was also a huge success. Here there was another capacity audience.

It is more than apparent that the said public is wide awake to their own interests.

As a step to relieve the burden imposed by war conditions on the medical profession, the adoption of two new, short, simplified statement forms to be filled out by physicians for their patients who have accident or sickness claims under personal accident or health policies is being recommended by The International Claim Association and the Health and Accident Underwriters Conference to companies writing these forms of insurance. The questions on the simplified blanks are designed to bring out the facts necessary to establish the claim. All other questions have been eliminated. Such a revision will be received with acclaim by the physicians, especially now when they are called upon to serve a vastly-increased number of patients and clerical help is at a premium.

Vox Pop continues to talk about the Indianapolis physician who refused to make out a birth certificate because he had not been paid for his services. We still are of the opinion that the doctor in question made an egregious blunder in taking that stand.

Bloomington faces the necessity of greater hospital accommodations, it seems. Only recently there was a rush of maternity cases, fifteen mothers being brought in for hospital care. Press reports state that every foot of available space in the hospital was used, beds even being set up in the corridors. Hospitals, generally, are "full up" these days.

Whooping cough seems more prevalent than usual, just now, some centers reporting an unusual number of cases. When it is recalled that this disease causes far more deaths during the first year of life than any other disease affecting infants, it behooves us to be on the alert when called to see such cases. The trouble is that too often the parents do not recognize the seriousness of the disease; do not call a doctor; and too often do not make any effort to confine the child to the home.

The *Crown Point Star*, in an editorial "From Rut to Grave," in speaking of the Wagner-Murray-Dingell Bill, makes the following comment: "It would open a road which would lead straight to a monstrously-extended Federal bureaucracy of such power that America would inevitably be transformed into a totalitarian state." There can be no question but that the American press is fully alive to the dangers of such legislation, realizing that not only does this hit at one of the professions but is an entering wedge for more vicious legislation to come.

Now comes a new field of war activity, chiefly for the women folk — that of providing bandage material, which presently is one of our acute shortages. Good bandages for both hospital and Army use can be made from reclaimed material, it is announced. According to a news story, Bloomington is to be one of the first cities to engage in such a program. Also, the Women's Field Army of Marion County has taken upon itself a similar task. One of the most striking lessons of this war is the fact that we long have been a wasteful nation, and that many things thrown into the discard pile have a real tangible value. Witness the scrap drives, the tin-can drives, the "save the grease" campaigns — each of these is a perfect thrift lesson.

It is probably a bit early to start talking about Indiana tomatoes, a favorite subject of ours, but we note that several packers already are advertising for "acreage" in several of our country weekly newspapers. The contract price offered, thirty dollars per ton for Grade A tomatoes, seems attractive, hence we may expect the Hoosier state to again hold first place in tomato production.

Alackaday! It appears that we will have to send to Vermont for our maple syrup, this year. A letter from a Clinton County physician, who for years has produced about the best article of this kind, advises that his camp will not be opened this spring, due to shortage of help and the fact that the sap does not look very promising. It has been a long time since we had to go outside the State of Indiana for our annual supply of this delectable article. After having used it for more than six decades, we had come to believe that it was just a bit better than that produced in other areas.

While making a purchase in a local store, the young lady who was supplying our wants asked if we knew a certain doctor, one of our own boys now in service. She stated that her boy friend had been injured, and that the doctor mentioned was caring for him—further, that the nurse on the case was from the home town of the injured soldier. She went on to say, "He writes that the men in his service have the best medical care, that the doctors and nurses are tops and see to it that the sick and injured get the best of attention." The young lady was quite enthusiastic about it, and of course we took full advantage of the opportunity to say a bit about what might happen if the Federal Government took over the matter of medical care. She agreed that we were right about it!

"Where can I get a hotel reservation in Indianapolis?" came the plaintive call from one of our patients. She wanted to attend a convention in that city some two weeks hence and had written three of the larger hotels for a reservation, only to be told that they were "full up" for that meeting. And, so we are advised, the same thing applies in most of our larger cities. Hotel reservations are made weeks in advance, if you get one. So, if you are planning to attend the state convention, come next September, and wish an advance reservation, *right now* is the time to attend to it. Of course, the local housing committee will see that you get a place to sleep, even though you neglected to make an advance registration, but there is nothing like being able to barge into a crowded convention city and walk up to the desk and say, "I have a reservation." Better write for this today!

"How to write a prescription" long has been a controversial point in some circles, and the Medical College of Virginia has launched a program that may, in time, be the answer. A communication from the Department of Pharmacology of this college states, "One of the most difficult problems in the teaching of medical students is that of prescription writing." It goes on to say that a prescription is a message from a physician to a pharmacist, and that an understanding between the two is vitally necessary. In the Virginia school the plan of having this subject specifically taught recently has been adopted and a course of eight lectures is given each term. Further, in this course the Federal narcotic laws are carefully explained. While the program is rather new, it is declared to be working out most satisfactorily. There is no doubt that this subject has not been very well taught in most medical schools.

One of our legal friends, whose hobby is that of delving into the laws of ancient peoples, comes up with this one, from a law of Hammurabi, the law having been promulgated some 4200 years ago. Hammurabi, it seems, was the King of the first Babylonian monarchy, in what is now called Iran.

"If a physician operate on a man for a severe wound (or make a severe wound on a man) with a bronze lancet and save the man's life; or if he opens an abscess (in the eye) with a bronze lancet and saves that man's eye, he shall receive ten shekels (as a fee).

"If with a bronze lancet a physician operate on a man for a severe wound and cause that man's death; or with a bronze lancet open an abscess (in the eye) of a man and destroy the man's eye, they shall cut off his fingers."

The Bellevue Hospital Rapid Treatment Center was opened in New York City on April first. This is one of the war projects for controlling the spread of venereal diseases. The Federal Works Agency, in conjunction with the United States Public Health Service, financed the project. In his address at the opening exercises, Dr. John M. Gallagher, region director of the agency, made the principal address. He sketched the various steps in the present battle against these diseases, stressing the point that it took a long time to make the American public venereal-disease minded. He also pointed out that when an epidemic disease broke out in any section of the country, it caused a great furore; yet when we have each year a half million *new* cases of venereal disease throughout the nation, we are inclined to be complacent about it. The center is rather an experiment and its course will be watched with much interest by the medical profession.

Morris Fishbein recently called attention to the odd and unusual names which are awarded defenseless children at the time of their birth, having dug up a long list of such names. He urges parents to drop faddism in that regard and use sensible names, names that will appeal to the youngster when he grows old enough to know what it is all about. (The above thought probably was brought to mind when we learned that our latest grandson is likely to be christened "Steve"—and that in a family with a long line of good old Scotch names that have endured in this country since 1750!

We cannot resist another comment on the foresightedness of those who drew up the Indiana State Constitution, referring particularly to that Article wherein a state public debt is prohibited. We have been looking over some figures sent out by the Federal Public Roads Administration and note that throughout the nation the state road debt amounts to the sizeable sum of \$1,737,057,000. At a moderate rate of interest the annual due bill would amount to almost sixty million dollars. Indiana is one of seven states which have no such road bills facing them, while New York owes over two hundred fifty million dollars in such an account; Illinois, Arkansas, California and Louisiana each owe more than a hundred million dollars for road construction. Better keep an eye open for the "new constitution" chaps; they again are becoming active. We could well make a few changes, but if such a convention should be called, let us hope that the "no debt provision" will be maintained.

Dr. Arthur J. Cramp, long-time head of the Bureau of Investigation of the American Medical Association, recently became an honorary member of the Indiana State Medical Association, through his affiliation with the Porter County Medical Society, of which he has been a member for many years. For a long time he maintained his home at Chesterton, in that county. Doctor Cramp, born in London, England, in 1872, received his early education in that city. Later he came to America, and in 1906 he received his medical degree from what is now the Marquette University School of Medicine. In December of the same year he became a member of the editorial staff of *The Journal of the American Medical Association*, and a bit later he established the Propaganda Department, which afterwards became the Bureau of Investigation. He served as the head of the department for twenty-nine years, retiring as of December 1, 1935, since which time he has been living in Florida and North Carolina. Doctor Cramp founded and operated the bureau which became known throughout the country; it might well be termed the "F.B.I. of American Medicine."

It is reported that approximately ninety-five per cent of the patients admitted to the venereal disease rapid treatment centers, operated by the United States Public Health Service, up to January 1, 1944, were girls.

When the new state law requiring all motorists to show a financial coverage in the matter of traffic accidents went into effect, there was much speculation as to what it would accomplish and just how far it would be enforced. A partial answer is given in a recent report by Don F. Stiver, state director of Public Safety. In this report it is pointed out that while there are many drivers who have not complied with the law, this number is rapidly decreasing, and by the end of the current year practically every automobile owner will have complied with the law. In the month of February, alone, some 1,300 Indiana drivers were deprived of their driving permits, and a total of 3,499 permits had been suspended, 2,199 of these having been restored. It also was stated that in 68 per cent of traffic accidents the drivers were covered by insurance. Thus it will be seen that more than 30 per cent of the accident-causing drivers still are to be classed as irresponsible. However, we have an abiding faith in our State Police Department, and we feel certain that when they are given more time, many of the evils that have been with us will be dispelled.

A self-styled bureaucrat in Washington writes the American Medical Association, complaining that too many medical men do not append the "M.D." to their signature, and suggests that the Journal of the American Medical Association editorialize on the shortcoming. Lord bless you, we have been doing that in our own magazine for several years, and recruit a new member in the drive about once a month. We append the comment, as is:

M.D.—NOT DR.

"To the Editor: The physicians of this country, in connection with the preparation of many millions of forms required by various government activities, frequently neglect to have their degrees follow their signatures and at times prefix their names with the word 'Dr.,' providing no other evidence that they are doctors of medicine.

"This occasionally works a hardship on us bureaucrats because, in order to assure proper distribution of certain types of materials, supplies, equipment and services, we must determine that the applicant is a physician rather than a doctor of science, of divinity, philosophy, naturopathy, chiropractic, podiatry, chiropody or whatever.

"It will be appreciated if THE JOURNAL at some time might contain an editorial relative to this situation and the need for a doctor of medicine to identify himself as such when his having that degree is a prime factor in determining his eligibility under certain policies.

"D. H. McCARTER,
2147 O Street N.W.,
Washington 7, D.C."

The following editorial comment appeared in the *Terre Haute Tribune* of February 1, 1944, and merits the attention of the doctors:

THE DOCTOR AND THE LIBERAL

"Many who call themselves liberals have one outstanding trait. They are always kicking. The latest victim of this particular brand of liberalism has been the medical profession.

"Doctors have struggled in laboratories and at bedsides for centuries to learn the secrets of keeping the human body alive and healthy. Dread diseases have been nearly eliminated. The span of life has been doubled in a few decades. Pain and suffering have been reduced miraculously. Since the war, the performance of the doctors has been supreme. They have carried their hard-earned knowledge into the front lines with the result that hundreds of thousands of men will return to their families after this war, who would otherwise be rotting in foreign graves. The doctors at home are working night and day, literally without rest, to care for the sick and injured among the civilian population.

"A lot of befuddled schemers, whose blood pressure would have felled them long ago if a few competent physicians had not been at hand, are now telling the country that the medical men have got to do much better at once or Uncle Sam will step in and take care of our medical needs. But Uncle Sam never saw the inside of a medical school. After the shouting dies down it will still be up to the doctors to keep us healthy. Socialized medicine would do no more than make the government a bill collector for the doctors, payable in advance, with a large part of the money retained for bureaucratic activities.

"Medical advancement will be achieved by the doctors in the future, as in the past."

It has been evident ever since last fall that a movement was afoot to substitute political control for professional management in the Mary Sherman (Sullivan County) Hospital. The plan was to create a job as business manager and supervisor, at a salary of two hundred twenty-five dollars per month, and to fill this job with a man who had no experience in hospital management or hospital operation. It was planned that this man should begin work on April first. In February, the Sullivan County Medical Society asked the Board of Hospital Trustees for assurance that this change would not be made. No such assurance was given; therefore, the doctors refused to receive any patients at the Mary Sherman Hospital after March fifteenth. However, provision was made that should any emergency occur, such as a mine disaster or any other catastrophe, the hospital would be used and all of the victims cared for. In the meantime all patients from Sullivan County were provided for in the hospitals of the adjacent counties. By April first the hospital population had shrunk to about seven or eight bed-patients, and no new patients had been admitted since March fifteenth. The hospital board met on April seventh and decided to abandon their plan for the employment of a lay superintendent, and gave assurance that the present management would be continued. On April tenth the Sullivan County Medical Society met and voted to again receive their patients in the hospital.

President's Page

While Distinguished Service Crosses and Congressional Medals are being awarded to our men in the armed forces, we would like to nominate some men in civilian life for decoration. We would name the old doctors who have come out of semi-retirement to carry on a full-time practice during the emergency. These men are too modest to claim any credit for their action, but the rest of us know what it means for them to take their old place in the ranks.

They have reached the place where fatigue comes early in the day and stays long into the night. Long hours, long drives, exposure and loss of sleep are as dangerous to them as bullets are to our boys in the war. To know that the work one is doing may cause death at any time, and to keep on doing that work because of a sense of duty is heroism of a high order. Our hat is off to these old heroes!

There is a distressing shortage of doctors in Indiana, and there is nowhere to look for replacements; so the situation must grow worse till the war is over. It may be that our committees, whose duty it was to pass upon the availability of men in each county, merely counted noses and did not take into consideration the age of those left or the likelihood of a long war. At any rate, all of the counties were swept pretty clean.

The cities do not feel the lack of doctors as much as the country districts. The most abundant facilities for the care of sickness are always found in the most densely populated centers. It is in the small towns without hospitals that these facilities are most attenuated. Indiana is full of small towns and farms. In fact, there are only five counties in the state that have a population in excess of one hundred thousand people. There are but fourteen counties that have more than forty thousand. This leaves seventy-eight counties with populations ranging from thirty-seven thousand down to slightly less than four thousand. This means that more than eighty per cent of Indiana is a rural area. In most of this area medicine is practiced the hard way; it is country practice. Here all of the patients must be seen in the doctor's office or in their own homes. The nearest hospital is sometimes miles away.

It is in these outlying districts that the older doctors have shown what their profession means to them. Here where the going is toughest and where the financial return is the smallest the old fellows are in there pitching.

We have been told of one county in the state where no one now practicing is under seventy years of age. This county has upward of sixteen thousand inhabitants. The largest town has less than three thousand people, and there is no hospital.

Such doctors should have a citation for meritorious conduct, for courage and devotion to duty, above and beyond what anyone could reasonably expect of them.

Joseph

A RESUME OF THE EYE TREATMENT PROGRAM SPONSORED BY THE INDIANA STATE DEPARTMENT OF PUBLIC WELFARE IN 1943

JEAN R. KETTLER, A.B.

INDIANAPOLIS

The Eye Treatment Program directed by the Indiana State Department of Public Welfare has completed its seventh year of offering medical and surgical ocular services to the indigent of Indiana. When the program was inaugurated and applications for eye treatment were steadily being received by the county and state departments of welfare, there were some who whispered that this activity would last for awhile but that it could not keep up indefinitely. Surely a time would come when every interested candidate for eye surgery would be reached and our program would lapse from exhaustion of material. However, this has not happened, for while the actual number of persons treated during the past year shows a slight decrease under previous years, the decrease is not due to a lack of candidates. Fewer persons have been treated because of increased time required in making and completing case plans.

Departure of doctors to military service has had a direct bearing on the activity of the program. Appointments must now be made months rather than weeks in advance. The specialist whose office was twenty-five miles from the home of the recipient has gone to war, and some patients must now travel one hundred and twenty-five miles for ocular treatment. How to get the patient to the doctor's office has become a major problem in the face of over-crowded carriers and gasoline and tire rationing. All these factors contribute to the anxiety of the already nervous surgical prospect, and the social worker finds that individual case planning requires more time, more interpretation, and much more patience.

Our experience has taught us that persons seen through the eye treatment program are, as a group, poorer surgical risks than those usually seen by the physician in his private practice. We refer to our statement in *The Journal of the Indiana State Medical Association* of May, 1943: "However, it must be recognized that most of the people seen through the eye treatment program are deprived people, and their deprivation has unfavorably influenced their physical condition and consequent convalescence." Therefore, it has become established procedure to try to learn as much as possible about the physical and mental problems of these people before they are brought in for hospitalization. To accomplish this, we have solicited the services of the general practitioner in the local community in making complete and accurate physical examinations, and the cooperation of the county department worker in referring only those cases

where visual restoration will mean social rehabilitation of the individual and in which the patient himself feels the definite need for eye treatment. To date these efforts have not brought the results originally anticipated, for we still meet at a referral center the patient with a physical report showing a negative urine analysis, when upon hospital admission tests show a 5 plus sugar and a blood sugar of 300 milligrams; or a person who does not actually want to see, and who wilfully gets out of bed or tampers with the dressings to delay or prevent his cure.

We cite the case of crippled, deaf, blind, mentally confused, and diabetic Mrs. C, whose immediate family felt that the solution for all her problems was the restoration of her sight. Although Mrs. C's family knew that she was a diabetic and required insulin three times a day, they had turned her care over to a mental-defective husband, who in a careless fashion gave unmeasured dosages of insulin irregularly. The family had glibly repeated the phrase they had learned, "her blood sugar is stabilized and she is under control," but they did not have laboratory records to substantiate their statements. It had been almost two years since she had seen a doctor. Thus, upon admission to the hospital her blood sugar was 355 milligrams and three weeks' hospitalization was necessary to get the diabetes under control. The cataract was removed, but the surgery was followed by a diabetic hemorrhage and secondary glaucoma, with the increase in the intra-ocular pressure making a second operation imperative.

After all this, her prognosis remains poor. The treatment of the patient's diabetes is substantially now as before, despite explicit instructions to her family for her diet and insulin dosage. Neither the general practitioner's report nor the social worker's advice could have discouraged this family from insisting upon treatment. In a case of this kind the first step in the treatment program lies in educating the family in proper care for a diabetic and in faithfully carrying out the instructions of the attending physicians.

When hospitalization costs accumulate with the rapidity of Mrs. C's, the average cost of eye treatment cases is correspondingly increased, since the total expenditure for the year is divided by the number of cases receiving treatment. In 1939 and in 1942 the average cost of a case, including surgeon's fees, hospitalization, et cetera, was estimated at \$160.27 and \$179, respectively; while in 1943 the average rose to \$189.73. This increased

cost per case is due, first, to the increase in hospital rates; second, to inability to arrange ward care which necessitates private room care; third, to lengthened periods of hospitalization, often because of inability to schedule surgery immediately; fourth, to increased transportation costs; and fifth, to preliminary examination and preoperative care.

During the year 1943, 103 individuals, 65 men and 38 women, underwent surgery for cataract extractions. Half of this group, 52 to be exact, were in the age group from 70 to 79; four were 49 or under; eight were in the age group from 50 to 59; twenty-nine ranged between 60 and 69 years, and ten were over 80. Of the group of 103, 78 had applied for eye treatment only. Thirteen were recipients of blind assistance at the time they received eye treatment, and all but *one* were removed from the rolls of blind assistance because they became visually ineligible following operations which restored their vision to better than 20/200. Twelve individuals were recipients of old age assistance at the time they were granted eye treatment. Practically none of the cataract patients was restored to economic usefulness, because of age, and even though they were again sighted people many continued to have an economic need and to be family or community problems. Eighty-nine persons were restored to a vision of 20/30 to 20/20. We are proud of this record.

Ocular surgery was not a first-time experience for some of these above-mentioned people. Five had previously been operated for cataract (three under the eye treatment program), and four had a previous capsulotomy or needling. The program arranged for five pterygium removals, two filtering operations for glaucoma, and two tear sac removals which the surgeon deemed a prerequisite to successful surgery.

A survey made in 1940 for the Social Security Board stated that 13 per cent of the blindness in Indiana was due to glaucoma. A breakdown as to the age of these recipients showed that 34 per cent were in the age group of 60 to 69, and that 31 per cent were 70 to 79. This meant that if the disease had its onset when the person was 40 to 50, the glaucoma was in a very advanced stage and probably beyond remediable medical assistance. We were concerned when we checked the cases of recipients of blind assistance against those receiving eye treatment for glaucoma through this program, for we found that only two recipients were under care. Although each eligibility eye examination had been thoroughly reviewed by our state supervising ophthalmologist to determine the need for medical and surgical treatment, as well as visual eligibility for blind assistance, we feared we had missed some potential treatment cases. Therefore, a desk review was made of all recipients who were blind from glaucoma, but the findings were identical with the earlier study. Again, most of the assistance recipients were 60 to 69 years of age, and the average age at the onset of blindness was 51. The majority qualified for blind assistance

because their central vision was reduced below 10/200, and those few whose central vision was better than 20/200 but presented fields which were contracted horizontally and vertically to a diameter of much less than twenty degrees. A greater number of women than men had glaucoma, and this seemed to be the only fundamental difference from the study in 1940, when the number was approximately the same for each sex.

We then checked the number of persons who had received treatment for glaucoma and found they totaled 79, or 4 per cent of the eye treatment cases. As the reader will note, the percentage ratio as to the treated and the cause are very much out of line. In 1943 only fourteen patients (10 women and 4 men) received treatment for glaucoma; of these twelve received medical treatment, one surgical treatment only, and one had combined medical and surgical treatment. Only two of the fourteen cases were new cases, the other twelve being old cases under regular observation.

At the meeting of the Conservation of Vision Committee of the Indiana State Medical Association in September, 1943, the chairman brought out forcibly the need for the control of glaucoma, the most insidious of all eye diseases. Our social study substantiates the need for this control, and shows the social problem of dependency which can and does result from the lack of control. Our agency stands ready to become a part of any drive instigated for the control of this disease.

The major medical and social problem seems to be how to locate the cases which are not coming to a doctor's office for medical care. Since dissemination of knowledge to the public seems to be *one* method, we are preparing for county social workers a manual entitled "What Every Social Worker Should Know About Diseases of the Eye," to be distributed shortly. Much is written about glaucoma—the nature of the disease, some common early symptoms, suggested treatment, et cetera. Ready knowledge of the disease may mean that some mother receiving aid to dependent children, or a younger member of an old-age recipient family, may be urged to seek medical care because the social worker knew that rainbow-colored halos around lights sometimes indicates glaucoma. With established medical programs in every county, a doctor should find it easy to refer to the respective county department of welfare glaucoma patients who are indigent or whose income will not permit the burden of the cost of treatment.

Glasses for the correction of refractive errors were provided for thirty-eight persons, but two failed to call for their glasses. A second pair of glasses was given to eight additional persons who had had previous cataract extraction and whose first lenses were no longer effectual. The total cost of glasses including those provided following surgery (103) and for the correction of refractive errors totaled \$1,912.99.

Routine sulfanilamide treatment for trachoma was administered to nine new patients, and seven

old patients returned for a second course of therapy. The total cost of this treatment was \$134.90, or an average of less than \$8.50 a patient for medical treatment only. Two persons were unable to complete the outlined medical plan because of their intolerance to the basic drug. Three persons had lid surgery prior to medical treatment, but those were classified as surgical cases since the correction of the entropion was the major treatment.

Five patients, four men and one woman, had surgery to remove pterygia, only one person underwent enucleation as a precaution against the development of a sympathetic ophthalmia, and each of two had an eye removed following an unsuccessful operation. Cases of optic neuritis, macular degeneration, and chronic conjunctivitis were treated medically and kept under close observation.

The need for general medical care among the less privileged is always prevalent. The systemic care is divided into two general classifications: (1) treatment to get the patient in condition to undergo eye surgery later; and (2) physical treatment to prevent further visual loss. Conditions treated included diabetes, hypertension, specific infections, tuberculosis, avitaminosis, while special care was given to remove foci of infection which seemed to constitute a threat to the physical or ocular health.

The actual number of cases completed in 1943 was 209. The State Welfare Board approved eye treatment funds for 217 additional cases in 1943, thus making a grand total of 1766 cases approved for eye treatment since 1936. On January 1, 1944, the number of cases carried over as uncompleted were 108. Seventy-five new applications (61 for eye treatment only, and 14 for monthly assistance and eye treatment) have already been filed in 1944. Eight old cases whose applications were still active

have applied for additional care. Six cases have been recently closed, making the total now under care 185.

In the fall of 1943 a special informational study on conservation of vision was made, under the auspices of the State Department of Public Welfare, by a DePauw University student. An inquiry was directed to each state, asking for information concerning its program for conservation of vision; what agency or agencies had assumed leadership in the organization of the program; and if a division of responsibilities prevailed, what agencies participated. Forty-one states and several provinces in Canada sent replies and literature, where available, about their programs.

Fifteen states replied that they had no program, and two that such programs were in the process of organization. It was not uncommon to find in some states that the Conservation of Vision Program was allied with the State Rehabilitation Program. In others, the State Medical Association and the State Department of Public Welfare shared jointly in initiating the program. Still others reported that their programs were entirely medically directed and assisted in by medical officers of local committees. Our sister state, Illinois, probably has the most highly-organized program, "The Illinois Society for the Prevention of Blindness," which is medically directed but supported by private subscription.

Conservation of vision is a comparatively new movement, but its development has been hindered by the war. Certainly, when the world is at peace there could be a no more challenging program to the doctor, to the social agencies, to the home and school, and to every individual than the *conservation of vision and possible prevention of blindness*.

ABSTRACT

CRITICAL SHORTAGE OF QUINIDINE

Because of the critical shortage of quinidine, physicians, hospital administrators and pharmacists are asked by *The Journal of the American Medical Association* in its April 22 issue to cooperate in rigidly restricting the drug to prescription use for the treatment only of heart disease. Quinidine is obtained as a by-product in the manufacture of quinine.

The Journal says that "For some time an acute shortage of quinidine has existed in the United States. Consumption has been high and replacement of present supplies practically negligible. As a result of its critical status, the Committee on Drugs and Medical Supplies of the National Research Council and its Subcommittee on Cardiovascular Diseases recommended that quinidine be limited to prescription use for the treatment only of heart disease. . . .

"Regardless of these proposals and the publicity given to them, consumption of quinidine has continued to be high. Ordinarily, about 80,000 ounces of the drug is used during a year; present stocks amount to between 29,000 and 30,000 ounces. It is the duty of every physician to prescribe quinidine only when no other drug will elicit a favorable response, and then only in quantities not exceeding fifty tablets for each prescription. Hospital administrators can provide much assistance by insisting that the members of the staff adhere rigidly to a program which provides for the restricted use of such critical drugs as quinidine. Pharmacists have a moral responsibility to release quinidine only on prescription. This is an emergency, and whole-hearted cooperation is essential."

GROUP-HOSPITALIZATION*

WILLIAM J. BURNS

LANSING, MICHIGAN

In the United States, hospital service now covers 13,000,000 people via the Blue Cross Plan, which is operating in thirty-six of the forty-eight states.

In Michigan, even the most optimistic have been astonished at the way the group-hospitalization program has developed. Five years ago there was *no* such plan in Michigan. Today a fifth of our entire population—which means well over a million persons—belongs to this plan, and there is no indication of a stopping point. There is only one explanation of the phenomenal growth of the Michigan Hospital Service—that explanation is “public demand.”

We feel that we—in common with the public as a whole—have a right to resent any suggestion that the Federal Government enter into this field. We have the best of proof that governmental intervention would be tantamount to denying a fundamental freedom with no valid cause. In large part the proof is statistical and categorical. It is not guesswork; it is fact.

In our state the public seized upon this new protection. In less than five years the initial Michigan Hospital Service organization of three persons in one small office has grown into an organization of more than three hundred employees, spread over eight floors of a building in downtown Detroit and through a dozen district offices in all parts of the state. The organization has over one million subscribers, covering one in every five persons in our state. More than a quarter-million patients have been hospitalized through the plan. Through it hospitals have received more than twelve million dollars. I shall not bore you with detailed statistics, but if you want these data they are available upon request.

At first the Michigan State Medical Society gave consideration to introducing its own hospital service program in conjunction with a medical service plan, but finally, in 1939, when it was definitely determined that the hospitals would sponsor the hospital service and the medical profession would inaugurate a medical service, the state medical society gave full support to the enterprise. Two enabling acts providing separately for hospital and medical service plans went through our legislature simultaneously—both with the backing of the hospitals and the medical profession. Supervision of the quasi-insurance phases of any corporations created under these Acts was placed in the hands of the insurance commissioner. Section one of Act 109 of the Public Acts of 1939 (the Groups Hos-

pitalization Enabling Act) states: “Nothing in this Act shall be construed so as to permit a hospital or other corporation to engage in the practice of medicine in violation of Act No. 237 of the Public Acts of 1899, as amended . . . or to contract to furnish the services of physicians to subscribers.” A clear-cut line has been drawn between what constitutes medical and hospital service, first by mutual agreement, in writing, between the Michigan Hospital Association and the Michigan State Medical Society, and second, in these two laws (The Group Hospitalization and the Group Medical Care Enabling Acts of 1939). Laboratory work done by Doctors of Medicine, including radiology, is not hospital service but the practice of medicine. It is not paid by the Michigan Hospital Service regardless of any contractual arrangements between the hospital and the individual Doctor of Medicine. Group Hospitalization and Group Medical Care plans should not be asked or expected to solve the problems of Medicine; only Medicine can and should solve the riddles of its own creation.

What I am trying to say is this: A hospital plan should pay for hospital service. The distinction as to what is hospital service and what is medical service is not one that could or should be settled by the plan. It must be settled by agreement between the doctors and the hospitals before the plan is inaugurated—before the enabling act is written and passed. It bespeaks the need for twin enabling acts.

You may be interested to know that the operating costs of the Michigan Hospital Service are less than 10 per cent of its earned income. Eighty-five cents of every dollar received from members goes out immediately to pay for service, and another five or six cents goes into a reserve for catastrophes, epidemics, or other contingencies. The director of the organization believes that eventually even this remarkably low proportion of operating cost can be halved—reduced to five per cent.

The requirement for enrollment in the Michigan Hospital Service is at least 60 per cent of an employed group of ten or more persons. Individuals leaving the groups through which they enroll are privileged to continue their memberships. Special arrangements have been made to enable the enrollment of members of certain professional associations—the Michigan State Medical Society, for one—and of farm bureaus, granges, dairy cooperatives, and the like.

Here is one of the results of the plan that affects physicians. Many of you, I feel sure, would welcome the ability to send your patients to the hospital for needed care without concern as to their

* Presented at County Secretaries Conference, Indiana State Medical Association, Indianapolis, January 23, 1944.

financial capacity. It is a consideration which often has considerable medical importance.

Further, I believe it is perfectly reasonable to touch on an economic matter which may be delicate but nevertheless is real. Doctors have to live, like any other people (amazing as this may be to some of your patients). Certainly they are more likely to become aware of it if the hospital bill—which regrettable custom has placed before the doctors—is paid in advance. *You* might be paid!

Finally, a point I wish to emphasize concerns physician-patient relationships. The hospital service plan does not disturb them. It is merely a method of paying hospitals. It works entirely within the framework of existing customs and institutions. If these plans are to change, it must be in response to the wishes of the hospitals and the medical profession for the very obvious reason that that is where they are controlled.

I believe that hospital and medical plans are im-

mediately necessary and that cooperation between physicians and hospitals in their development is essential to their success. I believe it is a case of getting them started *now*. So long as there is a single state in the union—especially a populous and influential state like Indiana—which has not made a substantial start in this direction, the Washington regimenters will have substance for their argument that voluntary methods will not work because they “ain’t.”

Here in Indiana you may still have doubts. We had doubts in Michigan. We did not *leap* into our program. There were fifty-four other hospital service plans in operation before the Michigan Plan began. But today I can truthfully say that our doubts have been removed. Our hospital service plan has done more—much more—than was expected of it. It is at once a public service and a bulwark against the perpetration of a great social wrong.

MEDICAL SERVICE PLANS—DISCUSSION*

L. FERNALD FOSTER, M.D.

Secretary, Michigan State Medical Society

BAY CITY, MICHIGAN

A discussion of Medical Service Plans can best be made by recounting some of the experiences of our trial in Michigan, which began in 1939 with the passage of an enabling act for the development of voluntary, non-profit medical service plans.

As originally designed, the voluntary non-profit prepayment Michigan Medical Service Plan, established by the Michigan medical profession through its official organization, the Michigan State Medical Society, was to be a Utopia of complete medical coverage.

A Medical Service Certificate was formulated, which covered nearly every type of medical and surgical service—everything from removal of a brain tumor to shots for a common cold—in the doctor's office, the patient's home, or the hospital, and was to sell for \$2.00 a month for individual coverage, \$3.50 for two-person coverage, and \$4.50 for family coverage. But when it came to selling this plan to the average middle-income class of working men, it was found that they were enthusiastic about the idea, considered such a plan a wonderful thing, but nevertheless did not enroll. The average man wanted something he could afford—something to take care of big bills.

So, in answer to this demand, Michigan Medical Service issued its Surgical Benefit Certificates, covering all surgical operations for the treatment of disease and injury, and the treatment of frac-

tures and dislocations; diagnostic x-rays; anesthesia by doctors of medicine; and obstetrical services after a ten-month waiting period (rendered while the patient is a bed patient in a regularly-accredited hospital) which originally sold for 40 cents a month for individual coverage, \$1.20 for two-person coverage, and \$2.00 for family coverage.

That this was the answer to the demand is evident in that since March, 1940, Michigan Medical Service had enrolled, to December 31, 1943, 616,416 subscribers, one out of nine of our population in Michigan, and has made payments of over six million dollars to doctors for services to subscribers.

We had no precedent on which to base rates. The original rates for the Surgical Benefit Certificate were based on statistics compiled by various government agencies in surveys of the cost and utilization of medical care, loaded two and one-half times to what was felt would be ample to cover the expected increased demand for service under a prepayment plan. However, after several months of experience it became apparent that these rates were wholly inadequate. No one had realized what a tremendous volume of service would be requested and received under a prepayment plan where all economic barriers preventing the obtaining of services, and where pre-existing conditions were not eliminated, were removed. The utilization of services as shown by the surveys, which was assumed to be normal, increased to over four times under the plan. Therefore, Michigan Medical Service found it necessary to increase the subscription rates twice,

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, January 23, 1944.

which now seem properly established at 60 cents a month for the individual certificate; \$1.60 for the two-person certificate; and \$2.25 for the family certificate.

The first essential in a solid foundation is provision for a more than adequate rate. Another most important factor to consider in laying a solid foundation for a medical care plan is the establishment of, and strict adherence to, sound enrollment regulations, as well as the maintenance of practical methods of stringent underwriting. Laxness in holding to the enrollment regulations—accepting groups with a low percentage of enrollment; accepting groups of less than the established minimum number; offering of a free protection period before the effective date of the certificate—and failure to check the experience of each group and to make adjustments where warranted would be fatal to any plan.

Another vital phase to be considered in the establishment of a medical service plan is the arrangement for paying physicians for their services to subscribers. As you all know, Michigan Medical Service operates on a *service* basis, payment for services rendered subscribers being made directly to the physician in accordance with an established schedule of benefits.

Setting up the entire Michigan Medical Service schedule of benefits has been left entirely in the hands of the doctors themselves. Committees from various fields of medical practice—ophthalmology, neurosurgery, radiology, urology, obstetrics-gynecology and other specialties—have met, and are still meeting with our Medical Advisory Committee to review the items in their particular field and give advice in the establishment of proper fees.

Since it is impossible, of course, to include in one schedule all the services that could be rendered by a physician, the Michigan Medical Service fee schedule is composed of the most common and frequent surgical procedures, the amount being the average payment for the average case. Unusual cases are reviewed by a committee of several practicing physicians who are qualified to determine a fair fee for the service. A flexible schedule and provision for professional review, to keep it in line with prevailing charges in your community, are necessary.

For economy of operation and effectiveness of combined presentation of services, consideration should be given to working jointly with a companion hospital service plan.

All phases of Michigan Medical Service enrollment are handled on a joint-operation basis with Michigan Hospital Service—solicitation of groups, certificate issuance, maintenance of subscriber records, billing and collection of subscription. We have

found that joint operation is especially important, in view of the present-day employment situation and shortage of material and equipment; the duplication which would result from operating two separate plans would today present an almost impossible situation, and would be too costly. Also, both tradition and logic are against separating two such services as closely related as hospital and surgical care. In the average person's mind there is no sharp distinction between them. Much better results can be accomplished by presentation of this combined health service.

The development of Michigan Medical Service obviously had to be made without the benefit of adequate actuarial and statistical data. As a result of this situation the corporation as of October 31, 1942, sustained a deficit of \$504,000. However, on January 18, 1943, this figure had been reduced to \$136,000, with fairly definite assurance that by the end of March the corporation will be operating without a deficit.

When that point has been reached, various procedures may follow—for example:

- (1) Reserves may be established.
- (2) Repayment of a 20 per cent pro-ration, established for a five-month period, to the doctors of medicine of the state.
- (3) An increase in benefits.
- (4) An increase in professional fees.
- (5) A lowering of subscription rates.
- (6) A more rapidly-increasing enrollment.

As a result of our experience, it would be well in considering the establishment of a Medical Service plan to consider the following suggestions:

- (1) Secure an enabling act—one separate from an act authorizing *hospital service*.
- (2) Begin with a program for catastrophic illness, viz., surgical service in a hospital—avoid a program of full coverage at first.
- (3) Do not establish rates *too low*.
- (4) Do not permit too rapid enrollment.
- (5) Have control in hands of Doctors of Medicine (majority of the board of directors).
- (6) Do not allow lay groups, such as labor or industry, to dictate details of operation and provisions.
- (7) Choose a director with great care.
- (8) As originators, be prepared to be “bumped” severely with criticism, and be prepared to give many hours of your time to the development of the plan.

Out of the welter of all the present-day uncertainties, one thing is certain: we must operate these plans; they must grow and spread if prepayment for medical service is to be a *voluntary* thing and not a *compulsory* program.



DIFFICULTIES IN ENFORCEMENT OF THE "EMIC" PROGRAM

THURMAN B. RICE, M.D.*

INDIANAPOLIS

It is evident that everyone wishes the soldier boys and their families the very best of everything. We are sure that no one is so selfish as to suppose that they are not worthy of the very best that this Nation can afford. We appreciate the difficulties which have been placed upon their young families—when they have families—due to the fact that men who had previously been making rather good wages have been taken into the Army. Army wages are good as compared with those of other nations but are still not luxurious by any means.

When we recall that the men who have in many instances replaced them in their jobs at home are receiving war wages, it does seem very unfair indeed. Then, too, when we consider that these men are not only separated from their families but are actually in great danger to life and limb, and that they are making tremendous sacrifices, in comparison with which the rest of us may feel that we are doing very little, it makes it all the more apparent that everything possible must be done for them at such a time.

So much is very clear, indeed, and we have no doubt whatever that Congress, when it came to voting this appropriation, felt exactly this way about it. "Nothing is too good for the soldiers" was evidently their slogan—and a very good slogan it was. A very simple law was written, covering the point—much shorter than laws generally are because the whole problem seemed so very simple. The plan was simply to arrange funds to pay for the obstetric and pediatric needs of the wives and children of the young men in service. This bill, in one form or another, has now been before Congress three times, and each time passed both Houses without a single dissenting vote, which indicates clearly that Congress had in mind certain very definite provisions. This cannot be called "New Deal" legislation because, as we have just said, everybody favored it, everyone in Congress voted for it.

As one reads the legislation that has been passed covering this subject, it is perfectly clear what Congress intended. By the time, however, we got the law interpreted and written into rules and regulations which were varied enough to cover all the circumstances, we found that the whole matter had become exceedingly complex, and with regard to its administration quite difficult to carry out. The law simply turns the administration of this large sum of money over to the Children's Bureau, which is, of course, under the Labor Department. The persons in executive positions in the Children's Bureau found it necessary to set up rules and regulations

which would be more or less uniform throughout the United States.

Now, the United States is a large area, and conditions differ exceedingly in various regions. There are, for example, many places in the United States in which ten dollars is considered a pretty fair remuneration for delivering a baby. Very little prenatal care is given—the physician simply goes to the home of the expectant mother and helps her until the delivery has taken place. Then, too, comparatively little postnatal care has been given in the past. On the other hand, there are places in the United States in which the procedure has become exceedingly expensive and complicated, with long hospital stays, special nursing service, anesthesia, surgical operations, and a great many other refinements—all of which are valuable and necessary if these women are to be given care on the level that is customary in that community.

So far so good. In the past, one community charged ten dollars or perhaps twenty-five dollars. Another community, in the case of well-to-do people, might charge several hundred dollars, and it was purely an arrangement between the physician and the family, and really no one's business except that of the physician and the family concerned. If the family could and wished to pay a large sum, they could have the services of the best specialist, the best hospitals and all that; if they did not wish to pay that much, they would get someone who was willing to work for less. It was purely a personal arrangement, just as one artist might be willing to paint a portrait for five thousand dollars while another would do it for fifty cents—the quality of the portrait being more or less commensurate with the fee.

When the Government is paying the bill, however, it cannot very readily distinguish between different physicians. So far as the Government knows, one is the equal of another, although common sense would indicate that such is not the case. It seemed absolutely necessary that there be a uniform system of fees provided, which has been arranged, and so here is the beginning of the trouble. It is not an easy matter to arrange such equitable schedules, we may be very sure.

The medical profession does not like the idea of set uniform fees because they understand that different cases require different care and that professional services vary widely in value. There is a professional and ethical principle here that is being violated. If the Government is going to pay out such money, records must be kept and rules observed. Obviously, public funds could not simply be given away to anybody that would ask for them. These records must be very carefully and honestly

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prepared. They must be filled out, filed and audited. In other words, there must be a great deal of "paper work." Physicians are very busy and do not like this "paper work," as can be well understood.

Then, too, the rules under which the fees are administered must be rigidly followed. There will obviously be a great many times when an obstetrical case does not fit into an accounting procedure very well. In such a case there develops what is known as governmental "red tape." It will be a little hard to see how governmental money could be administered accurately and without danger of graft if there were not some such arrangement. All this causes irritation on the part of physicians, and it causes a great deal of work on the part of health departments. It must be borne in mind that this function of government doesn't really belong to state boards of health, inasmuch as they were primarily designed for the purpose of preventing infectious diseases. As a result of this law, we are being drawn into something which is essentially *welfare or relief*. It was not our wish—we had nothing to do with the writing of the bill in the first place, or its passage in Congress, and we have had very little to do with the writing of the rules and regulations by the Children's Bureau. Perhaps to some extent those rules and regulations have been modified due to requests and pressure from the secretaries of state boards of health, but in general the Children's Bureau has the right to be somewhat dictatorial in this matter inasmuch as the funds are administered through them, and whoever holds the purse strings of course controls the policies. They are responsible for the over-all policy and therefore in self-defense must have rules.

In many places friction has arisen between boards of health and the physicians of the state because of this law. This is most unfortunate indeed. We are very much afraid that health work for many years to come may be injured by this feeling on the part of the physicians that "this is the entering wedge whereby Washington bureaucrats will soon have the medical profession by the throat." We *personally* do not have such a feeling because it is promised that this program will be discontinued as soon as the men are released from the Army, or possibly for the duration and six months thereafter. It seems to us that this should be an object lesson that would indicate the danger of such a law as the Wagner-Murray-Dingell Bill which is before Congress. If it causes this much trouble to administer some twenty million dollars a year, what would be the chaos if all medical care were placed under Government supervision? The condition would be calamitous in the extreme and utterly beyond imagination.

We want to remind the public and the profession that this law which was enacted under the highest possible motives is exceedingly hard to enforce. For example, supposing here is a physician who feels

that the excellence of his service and the time that he gives entitles him to a fee of two hundred dollars for an obstetrical case, it is his privilege to charge whatever he wishes because that has been the privilege of all physicians, with the understanding, of course, that he will not let people suffer when they do not have funds. Medical men have been very free, as everyone knows, in caring for those cases where there was no money and in offering their services gratis. In this case the soldier feels that funds have been arranged for by the Government. He does not want charity from the physician; he hasn't been accustomed to it; his family has been capable of living on a higher level; and he expects to return to such a level of independent living. He does not want the doctor to do this work for nothing and does not understand why he should. He feels that he can hardly afford to pay the bill himself with money that he gets from the Government, and he feels also that if he were not in the Army he would be making a great deal more money and so could pay his legitimate bills.

At such a time he is probably worried and feels that his wife should have the best care, and so he recommends that she go to the best specialist that she can get. This, of course, means that the specialist has three choices: (1) he must accept her at much less than his regular fee, which is hardly fair to him; (2) he must do the work for nothing, which is embarrassing to the soldier, or (3) he must turn down the case, which latter course tends rapidly to put him on the spot because it looks as if he is discriminating against a soldier's family.

We believe that there is a better way to handle this matter, but, of course, the law is not written that way. It seems to us that inasmuch as a child is really nine months old when it is born, and inasmuch as there is regularly given an allowance of twelve dollars a month for each child, that we could simply give the mother of the child the hundred and eight dollars a month ($9 \times \$12$) or some comparable sum at the time the child is born, or at an earlier period if she needs it earlier. She could then pay the bills herself. She could then engage the physician herself. Such an arrangement would not only take the heat off the health department but would also satisfy the medical profession much better inasmuch as it would permit smooth operation of the patient-profession contractual relation. It seems, too, that it would be more of a compliment to the soldier and his wife. That does seem to be a much simpler and better arrangement. The law, however, is not written that way. This is something for the public to think about.

As the matter now stands, we are in serious danger that the relations between the State Board of Health and the medical profession may be injured in our attempt to administer this law, which is so very laudable in one sense and so dangerous and difficult in another.



DOCTORS SERVING AS GENERAL PRACTITIONERS FIND DAYS TOO SHORT TO MEET ALL CALLS

(This article was reprinted from the Indianapolis Star of April 13, 1944, and was written by Mary E. Bostwick. In reporting the daily routine of this one physician, Miss Bostwick really portrays the life of every civilian physician at the present time.)

"Those emblems of industry, the busy bee, the cranberry merchant and the one-armed paper hanger may now move over and make room for the doctor who is a general practitioner.

"Surgeons and other specialists have all they can do, too, but it's the general practitioner who has to move so fast he sometimes appears to be little more than a blur if he wants to get everything done that must be done, and the reason is that while the population of Indianapolis, for instance, has increased by at least 100,000, about a third of the doctors are now in the armed forces.

"What is happening here is happening every place else, with the result that a doctor's most beautiful and extravagant dream is of a community where everyone is hale and hearty; where lungs, lights and livers perform as per schedule, where no one falls off a stepladder or gets run over by a truck and new babies considerably arrive during the daylight hours.

Eight-Hour Day Is a Laugh

"One G.P., to whom the eight-hour day and the five-day week are a big laugh, closed the door cautiously against a waiting room bulging with patients of all ages, laid aside his stethoscope as if it were a necktie, and took time out to tell of the situation in which he and his colleagues find themselves.

"All the general practitioners are about in the same boat, he said.

"My day begins, at the latest, at 8 A.M.," he said, "and I start out on my house calls and my hospital visits. The house calls are made on people who can't possibly come to the office—people just out of the hospital after an operation, people who are bed-ridden because of critical illness or who have been in accidents and are wearing casts. The doctor used to be called to the house for every little ailment, and he'd go, too, but not any more. Before the war I'd make thirty or forty house calls a day and now I can't make more than fifteen or twenty.

"I'm not a surgeon, but if any of my regular patients are having an operation, I try to be there, and if they get sick enough to go to the hospital, I look after them. Most doctors are on the staff of more than one hospital, and that means going all over town. After I've made my house and hospital calls, I come to the office.

Office Hours Lengthened

"My morning office hours are supposed to be from 10 to 12, but it's usually after 1:00 before I can get away, and maybe grab a little lunch. Then I make some more house calls, and try to be back at the office by 2 o'clock. I usually get there around 3 o'clock, and find the waiting room full—sometimes so full there aren't enough chairs for everybody to sit on. Office hours are supposed to be over at 4 o'clock, but they hardly ever are. If patients are in there before 4, I'll take care of them. After I've finished that up, there are more house calls, and if I'm lucky I manage to get some supper at home instead of snatching a sandwich someplace before I open up the office at 7 for the evening trade.

"In the evenings it's the same thing all over again. I'm supposed to close the office at 9, but it's often 11 or 11:30, and sometimes even midnight. After I leave the office, I make some more house calls. You would think by that time I was due for an uninterrupted night's rest, and I am, but I don't get it. As soon as I'm home the telephone starts ringing, and usually somebody is critically ill and I have to go out again.

Sundays Just as Bad

"Sunday are just as bad. Sometimes I think people feel sick all week, and then wait until Saturday night or Sunday to start calling for a doctor. Wednesday afternoon is a joke, too. You know that stuff about the doctors all going out and playing golf on Wednesday afternoon? If you see anybody playing golf on Wednesday afternoon any more, it isn't likely to be a doctor, if they're anything like me. Wednesday afternoon is the time I catch up on my clerical work concerning defense workers, and people who are off their jobs because they're sick, and insurance claims blanks, and stuff of that sort.

"A general practitioner can leave town for a couple of days if he wants to, but a lot of good it does him. I went down to French Lick for two days, and when I got back and went to the office, the waiting room was so full I could hardly get through. There were 104 patients treated at the office that day—the usual number is around 60 or 70.

Telephone Calls Nuisance

"Sometimes I wish the telephone hadn't been invented. One of the doctors' outstanding nuisances

is unnecessary telephone calls. People will call up when the office is packed full of people, and they'll hang on the line; they'll want to do all the talking themselves, instead of telling me briefly what the situation is and then letting me do the talking. Yesterday a woman telephoned me regarding her mother's heart condition; then she called her sister-in-law and the sister-in-law called me up to talk it over, then the sister-in-law told her husband about it and he called up to talk it over—I had to explain to all three of them.

"Some babies show up during the daylight hours, but most of them arrive late at night or soon after midnight. What does a baby care about a doctor's office hours? Accidents don't choose the most convenient times to happen, either. On one of my busiest afternoons here at the office they brought in a child who had fallen through the glass of a cold frame; I had to leave everything else and fix up the child's hands.

Serves as Own Druggist

"I'm my own druggist, too, and dispense my own medicines, as most general practitioners do, instead of having the patients get their prescriptions filled someplace else. I have to be a pharmacist and a chemist, and even an expert on family rows; now and then I have to testify in court. I have to deal with people who think they're sick when they aren't, and with the people for whom the war and wartime conditions have been too much and who are just about to go over the border line.

"People come to me with their rationing problems. They want me to see that they get extra meat points. Some of them want me to arrange for them to get extra gas because, they say, they don't have enough to make the trip to my office. They want me to contact the Red Cross and get a furlough for some soldier because the soldier's grandpa has just had his appendix out.

Examine Many Selectees

"Nearly every doctor I know has examined thousands of selectees for the draft, and hasn't got a cent for it—work we're glad to do, but which takes a lot of time. A lot of us have been doing this since the fall of 1940.

"I've noticed, though, that a good many patients are getting more considerate when it comes to wanting a doctor. They've finally realized there just aren't enough doctors to go around, and not enough hospital space, and not enough nurses, either. If you want to help a doctor out, the thing to do is to see that you don't get sick. If you're suffering from a cold or minor illness, go to bed, eat simple food, drink plenty of liquid and have the house heated properly. If you're suffering from a cold, don't go out hunting, or sit in stadiums watching football games or baseball games. I had several cases of pneumonia and pleurisy last fall because people hadn't had the sense to stay home from hunting trips and football games.

"An eight-hour day and a five-day week!—Ha!" concluded the G.P."

ABSTRACT: PROMISING MEANS OF PREVENTING RECURRENCE OF BOILS REPORTED

A possible means of preventing the recurrence of boils is reported by Philip B. Price, M.D., Salt Lake City, in the April 22 issue of *The Journal of the American Medical Association*.

Postulating that contamination of the normal flora or bacteria on the skin around a boil with the boil-producing bacteria is the primary cause of furunculosis, Dr. Price eradicates all the offending organisms from the involved area by continuous application of a solution of ethyl alcohol, exactly 70 per cent by weight, by rubbing it gently with gauze for about twenty minutes. This treatment is carried out after a boil has healed and before another one appears. It should be emphasized that the treatment of boils, like any other serious infection, should be by a physician.

In the last ten years many patients with furunculosis have been treated by this method, Dr. Price says, explaining that "Eleven of these cases have met the following criteria, and . . . form the basis of this report: (a) All 11 patients had true furunculosis; that is, a more or less continuous succession of deep-seated boils occurring over a period of several weeks or months. (b) All had been treated unsuccessfully by other methods. (c) All were treated personally by me in accordance with the principles outlined. (d) All were followed for two or more years after the alcohol treatment. In all the cases there was complete and usually sudden cure of the condition. And in none of them has there been

any recurrence of furuncles during the period of observation. . . .

"No claims are made for this method of treatment. The number of cases in which it has been used is too small to warrant any final conclusions as to its efficacy. My purpose in this communication is to present a rational theoretical basis for such a treatment together with the results which have been observed to date. It is hoped that wider use of the method will lead to an accurate assessment of its value.

"It is important that the alcohol solution should be prepared properly if full disinfectant action is to be obtained. . . .

"The germicidal action of alcohol on the skin is increased by friction, but in the presence of furunculosis rubbing is not without danger. Vigorous massage, particularly when directed against the normal inclination of hair shafts, may actually do harm by pushing live bacteria into hair follicles.

"After prolonged application of alcohol the skin feels dry and may itch slightly. Patients should be cautioned not to rub or scratch the region. It is advisable to powder the disinfected area with sterile talcum or zinc stearate. Calamine lotion may be used in selected cases.

"It is reasonable to suppose that in the production of furuncles infectious bacteria are first deposited superficially in hair pits, and that they are carried slowly toward the roots of the hairs by natural processes of reproduction and invasion, aided by rubbing, scratching and squeezing on the part of the patient. . . ."

A MESSAGE FROM THE SURGEONS GENERAL OF THE ARMY AND NAVY TO THE PHYSICIANS OF THE UNITED STATES

On March 18, 1944, the Emergency Maternity and Infant Care program for the wives and infants of enlisted men in the four lowest pay grades of the armed forces of the United States will have completed its first year. Approximately a quarter of a million wives and infants will have been given care under the program. More than ninety per cent of this number are wives of enlisted men; nearly ten per cent are their newborn infants. Medical, nursing and hospital care is being made available in Army and Navy installations where it does not interfere with the care of the soldier and where it can be given without increasing existing facilities. Whatever other care is available in the place where the wife and infant are living is being given through the civilian authorities.

Physicians the country over are contributing their medical skill to this wartime program generously and in return for moderate recompense. Hospitals the country over have opened their doors to these wives and their infants, making available accommodations where their medical needs can be met adequately, though without luxury care. Nurses the country over are helping in the city and the rural homes and in the hospitals.

All this is being carried out voluntarily by those who are participating in the program. All this is being done in spite of the great shortage of physicians and nurses serving the civilian population—a shortage caused by the entry into the armed forces of thousands of our physicians and nurses.

This program of maternity and infant care for wives and infants of enlisted men is made possible by grants from the Federal Government through the Children's Bureau of the Department of Labor and the state health agencies, for the purpose of relieving anxiety among the enlisted men as to how the costs of maternity care for their wives, or the costs of medical care for their infants, will be met in their absence from home while in the armed forces—when, for a great majority, their family income has been lowered materially. The program carried out by the state health agencies brings assurance to the enlisted men that their national and state governments are doing whatever is in their power to make care available to their wives and infants, that physicians throughout the country are helping.

The morale in the armed forces is being raised and our fighting men go overseas with greater confidence in the security of their families because of this wartime program.

We who are responsible for the health and medical care of the men in the armed forces are grateful to you—physicians, nurses, and hospitals—who are participating in this program of care for the wives and infants of these men. You are sharing with us our normal peacetime responsibility of caring for the families of our men, and so are making it possible for us to give our best efforts to the men themselves.

Your contribution is an invaluable aid to us in the prosecution of the war, and we count on your carrying this program forward in the year to come with the same generous spirit you have shown in the past year.

ROSS T. MCINTIRE,
Vice Admiral, M.C., U.S.N.,
The Surgeon General of the Navy.

NORMAN T. KIRK,
Major General, U. S. Army,
The Surgeon General.

Military News

Lieutenant Wendell E. Brown, of Indianapolis, has been stationed at the Naval Hospital in Oakland, California, for the past eight months.

Captain William M. Browning, of Indianapolis, now has a New York A.P.O. address. He formerly was at Camp White, Oregon.

Lieutenant Commander Nelson B. Combs, of Mulberry, has been transferred from Pensacola, Florida, to the Fleet Air Dispensary at Quonset Point, Rhode Island.

Edgar Bridwell, M.D., of Delphi, has been promoted to the rank of major. Major Bridwell is now in service with the United States Medical Corps in Sardinia.

We have been informed that Captain J. B. Berkeley, of Peru, is now at Pope Field, Fort Bragg, North Carolina, having been transferred there from the Sedalia Air Base at Warrensburg, Missouri.

Congratulations to Dr. Paul H. Beard, of Indianapolis, who has been promoted to the rank of commander. Commander Beard is located somewhere in the New Hebrides.

Word has been received of the change of address for Captain William D. Britton, of Indianapolis, from Camp Ellis, Illinois, to an Army post office address, New York City.

Dr. Marion M. Crum, of Angola, has been transferred from Maxton, North Carolina, and is probably happy about the move, for he is now stationed at Baer Field, Fort Wayne, Indiana.

Recent visitors in Indianapolis were Lieutenant Edwin W. Dyar and Captain E. Paul Tischer. Lieutenant Dyar is stationed at Pensacola, Florida, and Captain Tischer is stationed at Chanute Field, Illinois.

In a letter from Captain Nelson E. Boyd, of Free-landville, he states that he is now stationed in India, having been transferred there after several months' service in Burma. The rainfall, he states, is very heavy, especially during the Monsoon season, at which time it will measure twenty inches. The two diseases which they have to combat more than any other are "malaria" and "fungus."

Captain Dee Dar Gill, of Greenfield, is now serving at Phoenix, Arizona.

Captain Samuel Caplin, of Indianapolis, now has an Army post office address, at San Francisco, California. He formerly was stationed at Fort Sill, Oklahoma.

Another of our physicians now serving in the New Guinea area is Captain Fred R. Malott, of Converse, who is serving with a hospital unit there.

In a notice of change of address, Lieutenant Colonel John L. Hillery, of Silver Lake, indicates that he is now overseas. He was formerly stationed at Fort Oglethorpe, Georgia.

Word is received that Captain W. C. Callaghan, of Greensburg, has been appointed chief of the eye, ear, nose and throat staff at the station hospital to which he is attached. Captain Callaghan has a San Francisco A.P.O. address.

Dr. Justus M. Fleming, of Elkhart, has been promoted to the rank of commander. Commander Fleming is on duty with the Naval Medical Corps in England at present.

Lieutenant John Flick, of Indianapolis, is stationed at Patterson Field, Ohio. Prior to entering the Army, Lieutenant Flick was resident physician in ophthalmology at the Indiana University School of Medicine.

Dr. Martha Crandall, of Indianapolis, became Indiana's first woman Army doctor when she was commissioned a lieutenant in the United States Army Medical Corps, on March twenty-second. Lieutenant Crandall is a graduate of the Indiana University School of Medicine, and has been granted a deferment until July to enable her to complete a year as resident physician in pediatrics at the Indianapolis City Hospital.

Captain Charles J. Cooney, of Fort Wayne, has been transferred from the Don Ce-Sar Hospital, in St. Petersburg, Florida, to the Columbia Army Air Base at Columbia, South Carolina. He writes: "I certainly enjoy THE JOURNAL very much, not only for the excellent scientific material which is invariably contains, but also because of the close link it forms between the doctors in the service and our friends and associates in Indiana. Thanks for keeping it coming."

Lieutenant Arthur F. Hoffman, of Fort Wayne, has been transferred to Randolph Field, Texas.

From a recent letter we learn that Major M. W. Hillman, of South Bend, is "somewhere in the Pacific."

After spending a week in South Bend, Major George F. Green returned to his post in Oregon by plane.

Word has just been received that Captain R. W. Holdeman, of South Bend, has arrived safely in England.

Captain Roy T. Hynes, of Indianapolis, has been transferred from Camp Lee, Virginia, to a New York A.P.O. address.

We note that Captain E. L. Hedde, of Logansport, has been transferred from Albuquerque, New Mexico, to Kingman, Arizona.

Dr. Elmer G. Koehler has left Camp Bowie for an overseas destination. He sailed from New York a short time before Christmas.

Major Charles E. Kenyon, of Cambridge City, has been in England since January, and is at present in charge of a hospital train.

Lieutenant Commander Philip T. Holland, of Bloomington, says in a recent letter that he is to be transferred to Great Lakes, Illinois, upon being relieved of his present duty on board the U.S.S. Mississippi.

Major Paul J. Iske, of Indianapolis, says in a recent letter that he has reached his final destination, which is somewhere in the New Guinea scene of action. "We are now in the process of building a hospital, and will soon be receiving patients. We are all enthusiastic about the prospects of finally doing the thing we came into the Army to do." Major Iske is head of the medical service in the new hospital.

Major Arthur W. Kistner, Elkhart, now stationed in England, was made post surgeon to the field in charge of Medical Personnel of the Post on September first. There is a fifty-bed hospital near his quarters. His other hospitals are scattered, the nearest one being fifteen miles away. He has seen various parts of England, and says it reminds him of the rolling country in Kentucky. Major Kistner attended a Christmas entertainment in an ancient church of Norman architecture, at which time he had an interesting talk with the old bell-ringer.

Dr. Keith Hammond, of Paoli, has been promoted to major. Major Hammond has been on maneuvers in the mountains near Camp Roberts, California.

Dr. O. R. Lynch, of Marengo, has enlisted in the Army. He left March thirteenth for Carlisle, Pennsylvania. After a six-weeks' training course, he will be commissioned a captain.

We have learned that Dr. William H. Garner, New Albany, has been promoted to lieutenant colonel. Colonel Garner is serving at the Station Hospital, Camp Campbell, Kentucky.

Captain E. G. Neidballa, of Bristol, has been serving overseas since October, 1943. He is now "somewhere in Africa," working at a base hospital in surgery and x-ray.

Dr. W. H. Nutter, of Rushville, has been commissioned in the United States Army Medical Corps, and is to report to the Letterman General Hospital in San Francisco after completing a six weeks' training course at Carlisle Barracks, Pennsylvania.

Having just completed a special course in Anesthesia and Oxygen Therapy, Captain Roy A. Geider, of Indianapolis, is now on detached service for thirty days, in the anesthetic clinic of a station hospital in England. Prior to his assignment in England, Captain Geider saw much active duty in the African and Sicilian campaigns.

Word has been received that Major R. S. McElroy, of Anderson, arrived in England the first of the year. Since that time he has been taking a course in surgery, in a hospital in one of the larger cities there. Major McElroy states that he has been most fortunate in being able to attend lectures under and observe the work of some of England's foremost surgeons.

Word has reached us that Captain Donald Grillo, of South Bend, was on duty as surgeon and commanding officer of a station hospital in China. However, he expected to return to India. We quote: "This has been a great experience, having had a chance to be in all parts of the C.B.I. theatre. The Chinese are hard workers and are clean. Most of us like them better than we do the Indians. The weather is on the cold side, so we have to use charcoal stoves. We are now in the rainy season, but get no snow here. We use Chinese currency, but it takes quite a lot of it to do business here. As you know, it is quite cheap. We get plenty of food although we can't get everything we would want. This hospital is not too large, but I have had the responsibility of getting it started."

Captain James G. Shanklin, flight surgeon, stationed at Harlingen (Texas) Army Air Field, spent a week's leave of absence at his home in Hammond.

A newcomer to the Navy is Lieutenant Herbert F. Sudranski, of Indianapolis, who reported to Williamsburg, Virginia, last month for duty.

Captain Eugene Weiss, of South Bend, is in charge of the gastro-intestinal clinic at Fort Knox. He is also doing general medicine and anesthesia.

Major R. B. Stout, of Elkhart, has been transferred to the Fort Raymond Hospital, Seward, Alaska, where he is the chief executive at the Kodiak Hospital.

Recently returned from Africa, and now stationed on the east coast, Captain Norman M. Silverman, of Riley, paid the Hoosier state a visit recently.

Dr. Louis D. Smith, of East Chicago, has been promoted to lieutenant colonel, according to word received here recently. Colonel Smith is stationed at Sheppard Field, Texas.

After considerable duty at sea, Lieutenant Commander Fred W. Taylor, of Indianapolis, has been promoted to a commander. Commander Taylor is at present stationed at San Antonio, Texas.

Word has reached us to the effect that Captain Howard A. Stellner, of Pendleton, who is with a General Hospital and who had been at Fort Riley, Kansas, and Fort Leonard Wood, Missouri, is now abroad.

Lieutenant Ray G. Tharpe, of Indianapolis, has been assigned to a Naval service at Crane, Indiana. He is at present home on leave, after twenty months of service in the South Pacific as medical officer with a construction battalion of the Seabees.

Dr. Thomas P. Rogers, of Indianapolis, has been promoted to a commander. In a recent letter he states that he has been engaged in psychiatric examinations for the past year, but was expecting momentarily to be shifted nearer to scenes of active operation.

Captain Fielding P. Williams, of Huntingburg, who is with a field hospital somewhere in the Pacific area, recently sent a new address, and expressed appreciation for THE JOURNAL. Letters received from the members of our armed forces indicate that our magazine is reaching a large number, which pleases us immensely.

Major O. L. Wood, of Brazil, is now located at Camp McCain, Mississippi.

Lieutenant Leon J. Witkowski, of LaPorte, is now doing neurological surgery at a general hospital in Brigham, Utah.

Captain Fred L. Wilson, of Terre Haute, is now at the Station Hospital, Camp Reynolds, Greenville, Pennsylvania.

Captain Carl Porter, of Jasonville, and Captain John W. Woner, of Linton, who are serving with the United States forces in England, are now stationed in the same hospital.

Dr. Karl Vetter, of Elkhart, has been promoted to the rank of captain, effective December thirty-first. He is serving as flight surgeon at Salt Lake City, Utah.

Major Lowell R. Stephens, of Covington, is now stationed at Billings General Hospital, Fort Benjamin Harrison, Indiana. He was transferred there from the Gardiner General Hospital, in Chicago.

Captain John S. Stanley, of East Chicago, has been transferred from Camp Breckenridge, Kentucky, to Fort Harrison, Indiana. He has been assigned to the medical service at the Station Hospital.

Announcement has been made of the promotion of Dr. Everett W. Williams, of Columbus, to major. Major Williams at present is chief of the Neuropsychiatric Section at the Fort Knox station hospital.

On February twenty-seventh, Captain Jacob Rosenwasser, of Mishawaka, and Miss Dorothy Keinigsberg, of Chicago, were married. The wedding took place at the home of the bride. Recently returned to the United States, Captain Rosenwasser has been enjoying a thirty-day leave. He has served many months in the North African and Italian campaigns. In describing conditions under which our men are fighting, Captain Rosenwasser said that the rough terrain and adverse weather conditions are more responsible for holding back our troops than are the Germans. He said Italian roads were better described as a sea of mud, and that the natural fortifications the Germans have to their advantage will undoubtedly call for a long and arduous battle before the victory is finally ours. Captain Rosenwasser mentioned seeing Lieutenant W. D. Buchanan, another member, from Bremen, several times. Lieutenant Buchanan is serving with the Navy.

We quote in part from a letter written by Captain Charles E. Muhleman, of LaPorte, and published in the Bulletin of the LaPorte County Medical Society:

"As to some information about my Army activities: I have spent what will soon be two years here at Letterman Hospital, in the Out-Patient Clinic, and have continued to follow my line of pediatrics and allergy. This is fortunate for me, no doubt, but nevertheless I envy the men who have been overseas to get some new experiences.

"Mrs. Muhleman and I have both enjoyed living here in San Francisco, and don't think we could have been assigned to a better place even with a choice. And we are just about to say that we are at home here. The city has lost a lot of its color because of the war, but yet there is lots to see and do, as in any large city. We have enjoyed the fogs and even the sudden, profuse rains.

"I have had some contact with those patients who come in by ship and plane from overseas. I have heard some interesting stories from them, especially from the nurses and medical officers, but my contact with these patients is not as extensive as those of the ward officers.

"The Indiana State Medical Journal has continued to reach me here ever since I left practice, and that has furnished me good contact with you men back there. It was interesting to note that Captain Sanderson was decorated some time ago for his heroism while on New Guinea.

"I have not written to any of our congressmen relative to the proposed Wagner-Murray-Dingell Bill, but I shall not fail to do so. Thanks for sending the name of our congressman. Glad to hear that the society is informing the public via the local papers about this proposed legislation, and I for one certainly hope that we do not get any government-subsidized medicine. My present work gives me some insight as to what this might be, and I am sure that the patient appreciates our present style of medical practice against any proposed free-doctor care."

This dispatch is quoted from the St. Joseph County *Service Bulletin*, and was taken from a letter written to Dr. Ray W. Spenner, of South Bend, by Captain Floyd T. Romberger, of Lafayette, who was recently hospitalized in India for the second time with malaria, but who is now out of the hospital again. Captain Romberger is the son of Dr. Floyd T. Romberger, of Lafayette.

"As a justifiable precaution, I shall be unable to speak except in generalities, in compliance with our theatre censorship regulations. My unit is located in the depths of the jungle, where we have been making ourselves as comfortable as possible for these many months. Except for a brief period shortly after our arrival here, we have been living in bamboo huts, just like the natives. However, we Americans are not content to exist in the same primitive state as our local allies, so we exert every effort to improve our quarters as much as the

materials available and ingenuity will permit. Some of these basha, as the huts are termed over here, have been provided with wooden or concrete floors; a few even have curtains on the doors and windows. Almost all have been furnished with cane tables and chairs. The food has become very monotonous for the most part, as one would expect, when considering that almost everything comes from cans. Fresh meat is a rarity except for an occasional issue of duck. At a few of the outlying posts the men have been able to shoot a deer now and then, which provides a most welcome addition to the diet. Fresh vegetables, except potatoes and tomatoes now and then, are unheard of. Recreational facilities are very limited. Now one can see two or three moving pictures a week, sitting in open air theatres, having jungle verdure for a background. In almost all units a spirit of gaming exists, so there are rather frequent poker games. Sometimes the galloping dominoes are given a workout. Once a month each officer receives an issue of a quart bottle of V.O., an event which is anticipated for weeks by many. The people here are very poor and seem to have no knowledge of sanitation, consequently, disease is high among them. Our medical men have been doing a lot of good work in treating them, in places where they have no medical attendants. They do seem to appreciate what is being done for them. The native bazaars, where we are able to purchase a few necessary items when the Post Exchange articles are inadequate, are both filthy dirty and very expensive. Five- and ten-cent articles back home cost anywhere from thirty to sixty cents here. I saw one officer pay about fourteen dollars for a pair of inferior rubber boots which would cost only about two dollars in the States, but then I guess you can't buy the last at all there. The only medical man from Indiana whom I know is over here is Dr. Winfield Scott. I would enjoy knowing if there are any others over here. Unfortunately, I am unable to state my location. There is only one request that we have over here; that is that we get down to work and give the enemy 'the business' so that we can terminate this war and return to our homes. For a while I was following in Jerry's footsteps, but I was given a new job of commanding a company several months ago. Give my best regards to all the members of the St. Joseph County Medical Society. I hope that I shall have the pleasure of seeing each one of them after this is all over."

Some interesting notes gleaned from letters sent from time to time by Captain Raymond Nelson, of South Bend, to his wife at the time of the invasion of Sicily, have reached us through the St. Joseph County *Service Bulletin*. He is now somewhere in Italy.

"At present we are living in a grove of olive and almond trees. The almonds are still a little green, but at that they make pretty good eating. There are also a few pomegranates in our area. The other day I was in a lime grove, but the fruit is still too small and green to make limeade. A few

days ago I traded a package of cigarettes for two small but fine-flavored watermelons. Were they good! There are plenty of grapes, or 'vine bushes,' as our boys call them. Vine is wine, of course. The grapes aren't ripe yet but we are watching them closely. There will be some good trading then.

"We landed on the morning of D day, on the beach a few miles east of —. We set up our station as soon as we could get our equipment and landing craft off the boats, and worked there for three days. It was during this time that we had all the fun dodging the various things. The Navy was shelling directly over our heads, the targets being German tanks a short distance back. We saw a fair number of German planes, such as Focke-Wolf 190's and Messerschmitt 109's. We had the pleasure of seeing three 109's shot down in ten minutes—one right past our area. It sounds blood-thirsty, but we all cheered when it burst into flames and plunged to the ground. War does strange things to one. Very shortly our Air Force had the upper hand, and we haven't seen German planes for days now, except very high-flying reconnaissance planes. We were the first outfit set up to do surgery in Sicily, according to reports from headquarters, and we had some interesting days. Sicily is a rough country with some wide, fertile valleys. The majority of the towns are built on the tops of hills and are dirty and unpleasant-appearing. Some of the larger towns have a few nice buildings, which invariably are the Fascist headquarters. In one town which our forces had recently occupied, the rear of the Fascist headquarters building had been bombed. The local people were carrying out everything movable, even the plumbing and telephones. We stood and watched for a few minutes, and they grinned just like a bunch of boys. I guess they thought they had been paying for the things long enough and that they had a right to get some of them. It is hot here as far as climate is concerned, and a bit hot in other ways, too. However, I am safe and sound and haven't been scratched except for a few slight bruises from jumping hastily into foxholes, *and I do mean hastily.*

"I was in one of the towns and talked to an old man, probably about sixty-five, who had spent fifteen years in New York. A lot of the Sicilians have spent some time in the States. They would work hard there for ten to fifteen years and then come back to live the rest of their lives on the money they had made. He was friendly and spoke understandable English. He told me of some of the hardships under the Fascists and Germans, and how glad they are to be rid of them. The people of Sicily were really glad when old Mussolini got the gate.

"Things are still going fine with us. Yesterday, while visiting in a town, we took along a number of pieces of hard candy for the children. I don't know how long it had been since they have had anything of that sort to eat, but they were really glad to get it. As soon as we would pull our hand out of our pocket with a few pieces of candy, the children would seem to come out of the walls,

and before we knew it we would be surrounded by a regular mob of hungry mouths—all clamoring for a 'bon-bon' as both the French and the Italians call hard candy. If the mothers were there they would smile their gratitude, and more than once I noticed a tear in a mother's eye. Some of the kiddies would grab the candy and run away, but most of them were more expressive in their gratitude. It is rather hard to imagine what must be passing through the minds of a lot of these people. We know that at least some of them were given rather vivid descriptions of the ills that would befall them when and if the Americans came, and they were urged to resist with all their might. I can't help thinking that news of these things will penetrate Italy proper and have an effect on the will of the people there as far as Italy's part in the war is concerned.

"I have your letter of July fifth, telling of your activities on the Fourth. A few days after that we saw one of the most profuse fireworks displays I have ever watched. That first night when the show opened we had a ring-side seat, and we really had a chance to see what our fire-power could do. War is a truly terrible business. God forbid that America should become a battleground!

"I had to spend some time in a rather small town and while there I walked into a store. The owner talked English, having spent several years in Canada, playing with an Italian orchestra. I found a recording of an opera in his meager stock and wanted to hear it. He didn't have a phonograph in the store, but offered to take me to his house. I went, rather dubiously, down a very narrow cobblestone street, well covered with horse manure, and was then even less enthusiastic. We finally came to a large door which yielded to his huge key. (They have the most enormous locks here.) We went up two flights of very ordinary marble stairs, into a nicely furnished apartment. He showed me his phonograph, a fine Victrola made in the United States of America. He also had an electric phonoradio combination, but couldn't use it as the power is off in the daytime.

"I want to take some pictures of interesting scenes here—the deep blue Mediterranean, the picturesque small sail boats and the carts. The carts don't sound so interesting on first thought, but they are very colorful. They are frequently decorated with very ornate carvings, and in addition there are all sorts of scenes painted on the sides. Frequently there are even carved figures on each spoke of the wheel. The horses are decorated with fancy harness and many highly-colored plumes.

"I saw a rather interesting show last night. It was put on by some soldier talent, aided by some Red Cross personnel. The orchestra was excellent, and they had a ventriloquist-dummy act that was very nearly, if not as good, as the McCarthy-Bergen team. Day after tomorrow Jack Benny and some supporting cast is to be in this vicinity. It will be interesting to see them but personally I can't get too enthusiastic about them; I would gladly forego the pleasure of seeing any and all U.S.O. shows for a ticket back to the U.S.A."

News Notes

Dr. James Spigler, of Terre Haute, was elected president of the Indiana Tuberculosis Association at its annual election on April twelfth.

Dr. Lewis R. Thompson, formerly of Helvetia, Pennsylvania, has established offices in New Harmony for the practice of medicine.

Dr. Joy F. Buckner, formerly of North Manchester, has purchased a thirty-acre tract, including a Shakespearean mansion, at Bluffton, where he will open an office and will also make his future residence, according to the *Bluffton News-Banner*.

The county commissioners of Lagrange County renamed Dr. H. F. Flannigan as county physician. Dr. Flannigan will serve all county institutions for the year of 1944. He has held this post for some time.

Dr. F. R. Nicholas Carter, of South Bend, was elected president of the Northern Tri-State Medical Association at the closing session of the organization's annual meeting in Toledo, Ohio. He succeeds Dr. E. Benjamin Gillette, of Toledo.

Dr. Harriet M. Clark, formerly of Indianapolis, is now in practice at Oak Park and Chicago, Illinois. Doctor Clark graduated with the Indiana University School of Medicine class of 1939. She recently visited with friends in Indianapolis.

Dr. M. L. Ploughe celebrated his eightieth birthday anniversary March twenty-ninth. Dr. Ploughe is one of the oldest practicing physicians in Elkhart, and is an honorary member of the Elkhart County Medical Society.

Dr. Wilbur F. Smith, of Indianapolis, has been placed in charge of the Physical Standard Section, Medical Division of Civil Aeronautics Administration, Washington, D.C., and has moved his family to Alexandria, Virginia, where they will make their future residence.

A citation for "faithful and meritorious service" as civilians in the selection of men for the armed forces were presented to each of three Indianapolis physicians on April sixth. Drs. Frederick V. Overman, Daniel W. Layman, and Victor A. Teixler were the physicians honored in an Army-day ceremony at the armed forces' induction center.

Dr. Mark Piper, formerly of Rochester, has joined the staff at the New Castle Clinic. He had served thirteen months in the Medical Corps.

Dr. C. K. Bender, of Goshen, was named health officer of Elkhart County at a special meeting of the county commissioners. He will fill the unexpired term of the late Dr. C. B. Lunsford; the term will expire January 1, 1946.

A two-day health conference, under the sponsorship of the Indiana State Medical Association and the Indiana State Board of Health, was held on April 19 and 20, in the auditorium of the Indiana University School of Medicine. This was the second annual Industrial Health Conference, and was designed to acquaint physicians and industrial management with the problems arising out of the rehabilitation and placement of the physically-handicapped veterans. A more detailed report of this meeting will appear in our June issue.

BOOKS FOR RUSSIA

A request has been received by the Academy of Medicine of Cincinnati for medical books to replace those which have been destroyed in Russia. There is also need for funds for medical text-books and for translating them into Russian, as well as having them printed there. Any one who is interested in assisting this very worthy cause is requested to write the Executive Secretary of the Academy of Medicine of Cincinnati, 690 Union Central Annex Building, Cincinnati, Ohio, for further information.

MOTION PICTURE FILMS

The British Information Services report that they have two 16 mm. sound films available for use by medical societies or other interested groups. These films are entitled "Psychiatry in Action" and "Life Begins Again," showing what has been done in Britain in the field of rehabilitation. For further information, address the British Information Services, 360 North Michigan Avenue, Chicago 1, Illinois.

A.M.A. MEETING

If you are planning to attend the Annual Session of the American Medical Association, at Chicago, on June 12-16, you had better apply for hotel reservations at once. Hotel rates and a blank for requesting accommodations appeared on page 56 of the Advertising Section of the March eleventh issue of *The Journal of the American Medical Association*. Railroad reservations can be made thirty days in advance, and it is recommended that reservations for Pullman accommodations be made early in advance.

COURSE IN ELECTROCARDIOGRAPHY

An intensive graduate course in Electrocardiography is being offered by The Michael Reese Hospital, at Chicago, Illinois, on August 21 inclusive of September 2, 1944. This course is offered to the general practitioner and internist. For additional information, address the Cardiovascular Department, Michael Reese Hospital, 29th and Ellis Avenue, Chicago 16, Illinois.

DOCTOR FISHBEIN SPEAKS AT TERRE HAUTE

Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, spoke at three different meetings in Terre Haute, Thursday, March twenty-third; at a noon luncheon sponsored by the Kiwanis Club, at a dinner meeting held by the Vigo County Medical Society, and at an open meeting held at the Sycamore Theater in the evening. Doctor Fishbein voiced the opposition of the medical profession to the proposed Wagner-Murray-Dingell Bill, now before Congress, which he termed as having a double purpose in its conception: first, as a revenue-producing bill, and second, one that would produce revenue under the guise of humanitarian purposes. He further said, "You cannot legislate against disease; you diagnose, prescribe and cure it."

Dr. Fishbein also visited the new penicillin plant, Commercial Solvents Corporation, and paid tribute to this company and to the medical profession for their achievement in scientific research, saying that this enterprise is one of the finest results of American initiative, talent, work and inspired leadership.

AMERICAN PHYSICIANS' ART ASSOCIATION

The American Physicians' Art Association will have its Seventh Annual Exhibit at the meeting of the American Medical Association, Stevens Hotel, Chicago, June 12-16, 1944.

Everyone was impressed by the beauty of the Art Exhibition at the Atlantic City Session last year, but the 1944 Gallery in the main ballroom balcony will be even more beautiful and impressive.

Through the courtesy of Mead Johnson and Company there will be no fees for hanging and no express charges either way. The type of art to be exhibited includes personal work of the following types of medium: oil portraits, oil still life, landscapes, sculpture, water color, pastels, etchings, photography, wood carving, leather tooling, ceramics and tapestries (needle work). All pieces should be sent preferably by railway express collect, automatically covered with fifty dollars insurance. There will be about a hundred trophies, including medals and plaques.

Exhibitors should send *now* for entry blanks to Dr. Francis H. Redewill, Secretary, A.P.A.A., Flood Building, San Francisco; one entry blank should be used for each medium in which it is desired to exhibit.

EXAMINATIONS BY AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The general oral and pathology examinations (Part II) for all candidates will be conducted at Pittsburgh, Pennsylvania, June 7-13, 1944, with The Hotel William Penn as headquarters for the Board.

INDIANA UNIVERSITY NEWS NOTES

Dr. Russell A. Sage, assistant professor of otolaryngology in the Indiana University Medical Center, at Indianapolis, recently spoke to the students of the University at Bloomington on the subject of "The Tongue." Dr. Sage has conducted extensive clinical research on this subject. Members of the Monroe County Medical Association, pre-medical and pre-dental and medical and dental students, and the public were invited to attend the lecture, which was illustrated.

The current issue of the *Quarterly Bulletin of the Indiana University Medical Center* published one of its medical articles in Basic English, as an experiment, and asks alumni of the Indiana University Medical School, now serving in the armed forces in all parts of the world, to report "concerning the advisability of translating more of our discussions into this global language."

The reasons for the experimental use of the Basic English idea are set forth in an editorial in the *Bulletin* by its editor, Dr. J. K. Berman, as follows:

"In medicine, physicians have always spoken in a more or less basic tongue. Medical terms are usually of Latin or Greek derivation, and although slightly variegated in the different languages the stem is the same so that the word could be easily recognized by the scientists of all nationalities. The descriptions of disease, its symptoms, signs, and its management have been in the vernacular of the nation from which they originated. This has made necessary international abstracts with more or less accurate translations which are carried by various national medical periodicals. If some universal speech were used, this would be unnecessary.

"English lends itself best to this formula of simplification. There has been a trend away from the Greek names of operations for some time. Our classification of operations for filing is that of the Western Surgical Association, which advocates English words. Formerly, the removal of the vermiform appendix was classified as appendectomy or appendicetomy. Today we prefer to use the term 'excision of the appendix.' Since the word excision does not exist in Basic English, we would be forced to use the phrase 'taking of the appendix,' or 'taking out of the appendix.' Basic English does not attempt to take away scientific terms; however, these would be held to a minimum."

POST-WAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of May, 1919)

Major Charles D. Humes, Indianapolis — then in France — discussed "War Neuroses"; O. C. Breitenbach, M.D., Columbus, wrote on chronic throat and head infections; Scott R. Edwards, M.D., Indianapolis, reported a case of "Bacillus Fusiformis Infection," while H. R. Allen, M.D., also of Indianapolis, wrote on "Facts Concerning Club Feet."

* * *

Editor Bulson took to task some authors who, in their scientific articles, chose to mention some non-accepted products.

* * *

Other editorials concerned infection transmitted via the hands, a suggested reorganization of the Medical Corps, and the role of the Salvation Army in the recent World War I.

* * *

It seems that some medical author, in his lay newspaper column, had recommended that a man who had lost his "pep" should consult his physician. Doctor Bulson rather opined that when this occurred about the best cure was to dig up the golf set and the fishing tackle. (This was written for the May JOURNAL and is a rather good prescription even to this day.)

* * *

Prevention of typhoid fever was a subject generally discussed in medical circles at this time.

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Complaint was being made in certain sections of the state that physicians were neglecting their local medical societies. Now that most service men were back, it was argued that a special effort should be made to rejuvenate those societies that had not been very active.

* * *

Attention was directed to the fact that most proprietary medicines then on the market were available, under a different name, via the National Formulary.

* * *

Comment was made on the then present status of the Indianapolis City Hospital. For some years past there had been much criticism regarding this institution, but the editor felt that the property was then in good hands and being efficiently operated.

* * *

The Indiana State Board of Medical Registration and Examination was making another effort to broaden the reciprocity agreement with other states. A number of these states held that such reciprocity should apply only to those who had gained their Indiana registration via the examination route. At that time reciprocal relations were had with thirty-four states.

The editor commented on some produce prices some fifteen years earlier, and quoted a few. Eggs were nine cents per dozen; butter — plenty of it — twenty cents a pound; potatoes forty-five cents a bushel; oranges, fifteen cents a dozen, and chicken ten cents a pound. (We can remember when these prices would have been considered high.)

* * *

An Indiana newspaper had taken the medical profession of the state to task because of the defeat of a full-time health officer law in a recent session of the Indiana General Assembly.

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The United States Public Health Service had estimated that over seven million people in the United States were infected with malaria.

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The base hospitals at Camp Custer, Michigan, and Camp Travis, Texas, had been converted into camp hospitals.

* * *

The new Bloomington City Hospital had been dedicated to the men in service from that county.

* * *

Mosquitos from all camps or ports where United States troops were stationed were being collected for the Army Medical Museum.

* * *

Dr. R. L. Sensenich, South Bend, had been appointed chief of medical service of Government Hospital No. 36, at Detroit, Michigan.

* * *

Dr. Herman G. Morgan, Indianapolis, had been appointed past assistant surgeon of the United States Public Health Service Reserve.

* * *

Indiana physicians who had been discharged from service and had resumed practice were: K. L. Craft, Paul Hurt, A. F. Weyerbacher, Bernhard Erdman, E. F. Kiser and Carleton B. McCullough, all of Indianapolis; Frank Murray, Zanesville; J. I. Maris, Mooreland; H. A. Duemling, Fort Wayne; C. G. Rea, Muncie; and Larue D. Carter, of Indianapolis, recently promoted to the rank of colonel, was reported on his way home.

* * *

The Virginia Medical Monthly, for some years published by Dr. Charles M. Edwards, had been taken over by the Virginia State Medical Society, with Dr. Alexander G. Brown, of Richmond, head of the publication committee.

* * *

Efforts were being made by the Indiana State Board of Health to secure legislation requiring all employes of food-handling establishments to be free from infectious or communicable diseases.

Deaths

Eugene Bowers, M.D., of Vincennes, died March first at the age of sixty-seven. He was a graduate of the Barnes Medical College, St. Louis, in 1905.

* * *

James M. Billman, M.D., of Sullivan, died March twenty-seventh at the age of seventy-nine. He was a graduate of the Bennett College of Eclectic Medicine and Surgery, Chicago, in 1896, and had practiced medicine in Sullivan for the past forty-five years. He limited his practice to internal medicine. Doctor Billman was a member of the Sullivan County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Flavius J. Beck, M.D., of Columbus, died on March twenty-seventh at a local hospital. He was eighty-one years of age. Doctor Beck graduated from the Kentucky School of Medicine, at Louisville, in 1890. He served as a major in the Medical Corps during World War I. He retired from practice ten years ago. Doctor Beck was a member of the Bartholomew County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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Roscoe H. Beeson, M.D., of Muncie, died at a local hospital on March thirtieth at the age of fifty-two. He was a graduate of the University of Louisville School of Medicine, in 1918, and served in the Army Medical Corps during World War I. Dr. Beeson limited his practice to Internal Medicine, and was especially interested in diabetes, in which field he did considerable research work. Doctor Beeson was a Fellow of the American College of Physicians, and served as Indiana Governor of the college from 1928 to 1933, and had served as president of the Muncie Academy of Medicine and the Eighth Council District of the Indiana State Medical Association. He was a member of the Delaware-Blackford County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Charles Bernard Lunsford, M.D., of Goshen, died suddenly on March seventh at his home. He was seventy-two years of age. Doctor Lunsford was a graduate of the Chicago College of Medicine and Surgery, in 1907.

* * *

Benjamin N. Searcy, M.D., of Rising Sun, died recently at the age of sixty-seven. He was a graduate of the Illinois Medical College, at Chicago, in 1898.

* * *

George Foster Smith, M.D., of Lawrenceburg, died March twenty-sixth. He was sixty-nine years of age. Dr. Smith was a graduate of the Miami Medical College, Cincinnati, in 1897. He was a member of the Dearborn-Ohio County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Warren L. Stamper, M.D., of Indianapolis, died April second at his home. He was seventy-three years of age. He was a graduate of the Kentucky School of Medicine, in Louisville, in 1892. Doctor Stamper was a member of the Marion County Medical Society, having at one time served as its president. He was also a member of the Indiana State Medical Association, and the American Medical Association.

* * *

John Albert Thompson, M.D., of Brookville, died at Cincinnati, Ohio, on March first, at the age of eighty-five. He was a graduate of the Miami Medical College, Cincinnati, in 1884.

* * *

Colonel Frank Bolles Wakeman, M.C., died March seventeenth at Fort Monmouth, New Jersey. He was forty-eight years of age. Although he served in the United States Army, he had maintained his home at Valparaiso since 1916. Colonel Wakeman was graduated from the Indiana University School of Medicine in 1926.

Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

INDIANAPOLIS

October 3, 4 and 5, 1944

Society Reports

COUNTY MEDICAL SOCIETY OFFICERS

DECATUR COUNTY MEDICAL SOCIETY:

President, C. C. Morrison, Greensburg.
Vice-president, Boyd Mahuron, Greensburg
Secretary-treasurer, H. S. McKee, Greensburg.

DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY:

President, Robert D. Turner, Muncie.
Vice-president, Ferrell W. Dunn, Muncie.
Secretary, Bruce W. Stocking, Muncie.
Treasurer, W. J. Molloy, Muncie.

LOCAL SOCIETY REPORTS

Cass County Medical Society members held a meeting March seventeenth, at the Cass County Hospital. A number of guests were present, including the Woman's Auxiliary. Mr. E. A. Robinson, of Indianapolis, spoke on the emergency medical services of the Office of Civilian Defense.

* * *

Decatur County Medical Society members met March twenty-third, at Greensburg, for a business meeting and election of officers. Four members attended the meeting.

* * *

Delaware-Blackford County Medical Society members met at the Ball Memorial Hospital, in Muncie, on March twenty-first. This meeting was a regular business meeting. Twenty-five members were present.

* * *

Elkhart County Medical Society members held a meeting April fifth at Hotel Elkhart, in Elkhart. This was their annual scientific meeting. The guest speaker was Dr. Walter C. Alvarez, of the Mayo Clinic, who discussed "Migraine and 'Sick Headache.'" Fifty members attended the meeting.

* * *

Fort Wayne (Allen County) Medical Society members held a meeting at the Chamber of Commerce Building on March twenty-first. Dr. S. W. Donaldson, of Ann Arbor, Michigan, was the speaker of the evening. Approximately forty members were present.

* * *

Greene County Medical Society members held a meeting at the Freeman Greene County Hospital on March sixteenth. The meeting was devoted to a discussion of current problems of the society. Six members were present.

* * *

Huntington County Medical Society members held a meeting April fourth, at Hotel LaFontaine, Huntington, at which they entertained their wives. Mr. M. McCabe Day, who has a large collection of pictures of Huntington scenes and residents of earlier days, provided the entertainment of the evening. Thirty members and guests were present.

The Hancock County Medical Society members met at the Cozy Hotel, near Greenfield, on April twelfth. Dr. R. N. Arnold was in charge of the meeting. "Problems of the Mediastinum" was discussed by Dr. J. O. Richey, of Indianapolis.

* * *

Indianapolis (Marion County) Medical Society members met April fourth at the Indianapolis Athletic Club. "The Evaluation of Transverse Cervical Cesarean Section" was presented by Dr. G. W. Gustafson, and discussed by Dr. Carl P. Huber; "The Frequency of Choledocholithiasis" was presented by Dr. M. N. Hadley, and discussed by Dr. C. A. Nafe; and "Significance of Ocular Fundus Changes in Hypertension" was presented by Dr. Mortimer Mann, and discussed by Dr. A. B. Richter.

On April eleventh the topic of the meeting was "Correction of Protein Depletion by Means of Amino-acid Therapy." Lieutenant Colonel F. A. Rice, Chief of the Surgical Service of Billings Hospital, was in charge of the program.

At another meeting held on April eighteenth, a symposium on "Adrenal Cortical Hormone" was held. Dr. A. C. Corcoran spoke on "Physiology of Adrenal Cortex"; Dr. J. A. MacDonald discussed "Treatment of Addison's Disease"; Dr. W. F. Montgomery spoke on "Use of Cortical Hormone in Surgery"; and Dr. D. C. Hines discussed "Other Aspects of Use of Cortical Hormone."

On April twenty-fifth the meeting was devoted to a round table discussion on "Focal Infection." The moderator was Dr. John Cunningham, and the panel group was composed of Drs. L. A. Weed, J. J. Littell, Kenneth Craft, H. S. Leonard, J. T. Waldo, and M. S. Harding.

* * *

Jasper-Newton County Medical Society members met March thirty-first at the Noland Hotel in Brook. The meeting was devoted to a general discussion of current business matters.

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Jay County Medical Society members met at the Jay County Hospital, in Portland, on March seventeenth. This was a dinner meeting, followed immediately by a general discussion of interesting cases of "Nose Bleed," "Milkleg," and "Deformed and Defective Babies."

* * *

Knox County Medical Society members held a meeting on March twenty-first, at Vincennes. A general discussion was held concerning the Good Samaritan Hospital and its future potentialities of growth and service to the community. Twenty members and guests were present.

LaPorte County Medical Society members met at the Sheridan Beach Hotel, in Michigan City, on March sixteenth. Dr. E. S. Jones, of Hammond, presented a paper on "Gastric Carcinoma—its Relation to Peptic Ulcer." The paper was illustrated by a colored moving picture of a complete gastrectomy which had been performed by the speaker. Twenty-four members attended the meeting.

At another meeting at the Rumely Hotel, LaPorte, on April twentieth, Colonel O. Wilbur Sicks, of Indianapolis, who is now surgical chief of the Army hospitals in the Chicago area, spoke on "War Wounds and Their Surgical Treatment." Lieutenant Colonel E. R. Denny discussed his experiences in the use of penicillin in the Army hospitals of Chicago.

* * *

Madison County Medical Society members held a meeting at St. John's Hickey Memorial Hospital, in Anderson, on March twentieth. Dr. Russell Sage, of Indianapolis, spoke on "The Tongue and Its Clinical Significance." The meeting was followed by a Dutch lunch, with Drs. A. T. Jones, W. D. Hart, and F. B. Wishard as joint hosts.

* * *

Montgomery County Medical Society members were entertained at a dinner meeting at the Culver Hospital, in Crawfordsville, on March seventeenth. The guest speaker was Dr. Carl P. Huber, of Indianapolis, who discussed "Anesthesia and Analgesia in Obstetrics." The discussion was illustrated by kodachromes, depicting the technique of caudal anesthesia. Fifteen members and guests were present.

* * *

Putnam County Medical Society members held a meeting at Greencastle on March ninth. The speaker of the evening was Miss Ella Mahauna, who discussed "County Welfare Medical Aid." Thirteen members attended the meeting.

* * *

St. Joseph County Medical Society members met at the Indiana Club, March twenty-eighth. Mr. O. C. Durham, Chief Botanist, Abbott Laboratories, Chicago, presented "Everyday Problems in Inhalant Allergy." Thirty-two members and guests were present.

At a meeting held on April eleventh, at South Bend, Dr. Frank Scott, of South Bend, discussed "Varicose Veins, Their Diagnosis and Treatment." Thirty-three members and guests attended the meeting.

* * *

Tippecanoe County Medical Society members met at the Lincoln Lodge, Lafayette, on March fourteenth. Dr. Donald Cook, of Lake Zurich and Chicago, presented "The Cook-Fuller Theory of the Cause of Gastric and Duodenal Ulcer in Man." A discussion followed Doctor Cook's presentation. Thirty-three members were in attendance at this meeting.

At another meeting held on April eleventh, also at the Lincoln Lodge, the attendance was fifty-nine members and guests. Among the guests were laboratory technicians and members of the Veterinary and Biology Department at Purdue, and the Woman's Auxiliary. The program consisted of a discussion on "Cause of Fever and Immunization in Malaria," presented by Captain Lent C. Johnson, M.C.

* * *

Wabash County Medical Society members held a meeting April fifth at the Women's Clubhouse in Wabash. The program consisted of a demonstration of a surgical sewing instrument, both by means of motion pictures and actual exhibition. Eleven members attended the meeting.

WAYNE-UNION COUNTY MEDICAL SOCIETY

The Wayne-Union County Medical Society held a joint meeting with the Eastern Indiana Division of the State Dental Society, in Richmond, on March thirtieth, with forty members of the two groups present. Tom Hendricks effectively presented the Wagner-Murray-Dingell Bill and its many associated problems. After dinner most of those present remained for a question and discussion period, following which two motions were passed:

"That a joint scientific meeting of the two societies be held in the Fall of 1944, and that it was the sense of the group that an annual joint meeting is desirable.

"That letters be sent to the representatives of this district in Congress, informing them that it is the opinion of the two societies that the Wagner-Murray-Dingell Bill is undesirable in its present form and will not be effective in providing improved medical service."

Other societies may be interested in our "WAR MODEL" meetings. Our scientific program begins promptly at 5:00 P.M., with dinner served at 6:00, and necessary society business conducted during the dinner so that those who have to leave early may get away at 6:45 P.M. Following the dinner there is an opportunity for presenting questions and a discussion period for all who wish to remain. Since the first of the year this plan has resulted in a better attendance and seems to meet with general approval.

F. E. HAGIE, M.D., *Secretary*,
Wayne-Union County Medical Society.

Buy Bonds



for



Bombs and Bombers

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

The Twenty-Eighth Annual Meeting of the Indiana Academy of Ophthalmology and Otolaryngology was held on April 12, 1944, at the Indianapolis Athletic Club, at which time interesting papers were presented by Dr. David E. Brown, Dr. C. P. Clark, Dr. B. E. Ellis, Dr. Carl Harris and Dr. Carl H. McCaskey, all of Indianapolis; and Dr. H. Brooks Smith, of Bluffton.

At the noon Presidents' Round Table Discussion, Dr. Orris T. Allen, of Terre Haute, discussed "Physical Basis of Intelligence and Personality," and Dr. Russell A. Sage, of Indianapolis, presided.

The guest speaker for the meeting was Dr. Bennett Y. Alvis, of St. Louis, Missouri, who presented two intensely interesting papers: "Minor Surgery of the Eyelids," and the other following the dinner in the evening was "Operations for Correction of Ptosis."

At the business meeting the following officers were elected for the ensuing year:

President: Dr. C. A. Robison, Frankfort.

First Vice-president: Dr. B. D. Ravdin, Evansville.

Second Vice-president: Dr. Myron S. Harding, Indianapolis.

Secretary-Treasurer: Dr. Russell A. Sage, Indianapolis.

Editor of Transactions: Dr. J. Kent Leasure, Indianapolis.

Dr. Orris T. Allen, of Terre Haute, and Dr. Myron Harding, of Indianapolis, are the two new members on the Council.

At the invitation of Dr. Hugh Kuhn, of Hammond, the Academy is to meet at Hammond next April.

WOMAN'S AUXILIARY

to the

Indiana State Medical Association

President—Mrs. James Baxter, Jr., New Albany

President-elect—Mrs. F. M. Gastineau, Indianapolis

Corresponding Secretary—Mrs. John Habermel, New Albany

Treasurer—Mrs. A. W. Ratcliffe, Evansville

Press and Publicity—Mrs. A. B. Richter, Indianapolis

ALLEN COUNTY

Dr. Austin E. Smith, a member of the teaching and research staff of the University of Chicago, Department of Pharmacology, was in Fort Wayne on March 7 and 8 for a series of four talks, under the auspices of the Auxiliary to the Allen County Medical Society. At 8:00 P.M., on March 7, Doctor Smith, who also is secretary of the Council on Pharmacy and Chemistry of the American Medical Association, addressed members of the Fort Wayne

Medical Society and members of the Allen County Medical Auxiliary, at the Chamber of Commerce, on the subject, "Are Your Foods, Drugs, and Cosmetics Safe?" Preceding the meeting a No-Host dinner was served at the Fairfield Manor in honor of Doctor Smith.

On Wednesday, March 8, he spoke to the students of the International Business College at 9:00 A.M.; the students of Concordia College at 11:00 A.M.; and at noon he addressed the members of the Lions Club on the subject, "Drug Miracles in Modern Warfare." He also used the same subject for a radio talk over Station WOWO at 3:45 on March 7. Dr. J. L. Wyatt, president of the Fort Wayne Medical Society, conducted a "question and answer forum" with Dr. Smith.

CLARK COUNTY

At a recent meeting of the Clark County Auxiliary, Mrs. Allen L. Voiers, Clark County chairman to the American Society for the Control of Cancer, discussed the importance of "cancer control," for which program plans have been made by the auxiliary as sponsor.

Mrs. Lulu Graham gave a report on the Wagner-Murray-Dingell Bill.

MARION COUNTY

The Marion County Medical Society invited the Auxiliary members to its regular Tuesday night meeting, March 28, at 8:00 o'clock. Mr. H. L. Young, vice-president of the Eli Lilly International Corporation, spoke on "Conditions in the Orient and What the Future May Hold." He lived in China and India for seventeen years. He stated that advancement in transportation and communication has made them neighbors of ours, and that we must learn to understand them. China and India are the largest in size in the Orient. There are 500,000,000 people in China. In 1940 it took thirty days for him to return to the United States—now it takes five days by plane.

"The physical characteristics of the country there is much the same as in this country, but the people are different," he said. The average foreigner just comes in contact with the coast of China, he pointed out. Twenty years ago the principal way to get about in China was by canals, coolies, walk, and even by wheelbarrow. There was not much use of the auto at that time. In 1942 there were good motor roads inland several hundred miles.

Mr. Young said that the background of these people goes back more years than any one knows. There has been a remarkable change in modern thinking the past five years. The whole social structure has been against war. He pointed out that they have great strength of character. He called attention to the fact that there is much poverty, and he feels that as the people who have become united, in a way as never before, take advantage of the things we have to offer them, they will have

some relief from poverty. He thinks that there will be a gradual change in their standard of living, and that there will be a more or less common dialect in China. That was one of the chief difficulties before the war. Behind all of these different customs they are the same as we are, he stressed. They will take the best we have to offer and adapt it to their use.

There is no question that China will be opened up and that there will be electricity, roads, et cetera. Mr. Young reminded the group that China has given us many things—in culture and art: lacquer, porcelain, gun powder, and paint. He said that we can approach China in the same spirit that we do our own neighbor—on an equal footing.

In speaking of India, he said that it is entirely different from China. It is not a united and national country, but although it is of different nationalities there is one thought in the mind of all India—Freedom from Britain. He claims that one must get acquainted with this difference of nationality and religion before one can deal with India. Hindustan is the largest group. None of these people are native of India; all of them came there at one time or another. The actual native of India is somewhere in the hills. The Hindus comprise 200,000,000 of the 380,000,000 people of India. The Hindu is not war-minded, he declared. He said that they are vegetarians, and that they regard the cow as a sacred animal. No life of any kind is ever taken—including the reptiles. A Hindu never permits any man to look upon his women. They are kept at home. This leads to much sickness, particularly anemia, among the women. There are hospitals for women only, where only women physicians are permitted. The Hindu cremates the dead, and the ashes are taken to the sacred banks of the Ganges. Every Hindu wants a son. Mr. Young says we must remember that these people are trying to do what others are doing; they want a home, children, and food.

The Mohammedans are more war-like than the Hindus, and they number 80,000,000. There are many riots among the different nationalities, Mr. Young said. The people insist that the British instigate these riots. There are some tribes that like to fight, and they make good soldiers for the British. There is a group called the Parsees, who originally came from Persia. They are a small group and live on the west coast. They are progressive, intelligent, and are good business people and leaders in all professions. They do much for India, Mr. Young said.

There is no unification of these people as yet, Mr. Young observed, but it is coming faster now. The India Congress Leader, Ghandi, occupies a passive position now. He is the leader of about 200,000. Kehrú is another leader; he directs active resistants. He is an opposite to Ghandi, but they both want freedom. The Indians are taking some of the things we have to offer, but there has been a feeling toward the Europeans which is not exactly friendly. In conclusion, Mr. Young stated that they are looking toward us for help—physical and

spiritual. We must do it in a spirit of equality, and with tact.

Following Mr. Young's talk, Dr. Edgar F. Kiser gave a short, interesting, illustrated lecture entitled, "Medical History in the Making." He first told about Thomas Guy, who died in 1724, and who in his will established a fund for Guy's Hospital in London. Just recently Doctor Kiser received a pamphlet giving a detailed description of the results of the bombing in 1942. He showed pictures of the devastated ruins, and of the heroism of the nurses and doctors while trying to save as many lives as possible. Some of the hospital has since been rebuilt.

At the March meeting of the Woman's Auxiliary to the Marion County Medical Society, Lieutenant William J. Barkley, of the staff of the Billings Hospital, explained the treatment of "war neuroses." He said that this condition was erroneously labeled "shell shock" during the last war. This meeting was under the direction of Mrs. Chester Stayton, chairman of the Public Relations Committee, and was open to the public.

VIGO COUNTY

On March twenty-third Dr. Morris Fishbein gave a public address at the Sycamore Theater in Terre Haute, at eight o'clock. This meeting was sponsored by the Woman's Auxiliary to the Vigo County Medical Auxiliary. The principal subject was "The Wagner-Murray-Dingell Bill, as It Will Affect Tomorrow's Medical Service."

The members of the auxiliary had a cafeteria dinner at the Student Union Building at 6:00 P.M. preceding the meeting. All doctors' wives of smaller towns were invited to attend. Mrs. James W. Baxter, president of the Auxiliary to the Indiana State Medical Association, was a guest.

Books

BOOKS RECEIVED

ALLERGY IN PRACTICE. By Samuel L. Feinberg, M.D., Associate Professor of Medicine and Chief of the Division of Allergy, Northwestern University Medical School; President, American Association for the Study of Allergy, 1942-1943. 798 pages. Cloth. Price \$8.00. The Year Book Publishers, Incorporated, Chicago, 1944.

TEXTBOOK OF GENERAL SURGERY. Fourth edition. By Warren H. Cole, M.D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago; and Robert Elman, M.D., Associate Professor of Clinical Surgery, Washington University School of Medicine; Director of Surgical Service, H. G. Phillips Hospital, St. Louis, Missouri. 1118 pages with 559 illustrations. Cloth. Price \$10.00. D. Appleton-Century Company, Incorporated, New York, 1944.

INDUSTRIAL OPHTHALMOLOGY. By Hedwig S. Kuhn, M.D., Hammond. 294 pages with 114 illustrations. Cloth. Price \$6.50. The C. V. Mosby Company, St. Louis, 1944.

SYNOPSIS OF NEUROPSYCHIATRY. By Lowell S. Selling, M.D., Dr. P.H., Director, Psychopathic Clinic, Recorder's Court, Detroit, Michigan. 500 pages. Fabrikoid. Price \$5.00. The C. V. Mosby Company, St. Louis, 1944.

SYNOPSIS OF DISEASES OF THE HEART AND ARTERIES. Third Edition. By George R. Herrmann, M.D., Ph.D., F.A.C.P., Professor of Medicine, University of Texas, Director of the Cardiovascular Service, John Sealy Hospital. 516 pages with 107 illustrations. Fabrikoid. Price \$5.00. The C. V. Mosby Company, St. Louis, 1944.

THE BRUSH FOUNDATION STUDY OF CHILD GROWTH AND DEVELOPMENT. I. PSYCHOMETRIC TESTS. By Elizabeth Ebert and Katherine Simmons. 113 pages. Price \$1.50. Society for Research in Child Development, National Research Council, Washington, D.C., 1943.

PERSISTENCE AND CHANGE IN PERSONALITY PATTERNS. By Katherine Elliott Roberts and Virginia Van Dyne Fleming. 206 pages. Price \$1.50. Society for Research in Child Development, National Research Council, Washington, D.C., 1943.

ABSTRACTS

IDENTIFICATION OF POTENTIAL RHEUMATIC FEVER FAMILY URGED

"The public health approach to the control of rheumatic fever, like tuberculosis, may profitably begin with the potential rheumatic family," May G. Wilson, M.D., New York, declares in *The Journal of the American Medical Association* for April 22. Because susceptibility to the disease is inherited, the potential rheumatic family should be identified by a complete family history and kept under medical supervision, she says.

"At the present time," Dr. Wilson points out, "rheumatic fever holds a prominent place in medical discussion and investigation. It is generally agreed that, although the nature of the disease is obscure, susceptibility of the host is the primary factor in the development of rheumatic fever. That this susceptibility is on an age and genetic basis is supported by considerable evidence. . . .

"The responsibility of the family physician, pediatrician, cardiologist and clinic is not limited to the medical supervision of the rheumatic patient. A complete family history and adequate physical examination of every member of the family are advisable. When it is ascertained that one is dealing with a potential rheumatic family, instructions as to the nature of the disease and its (various) manifestations should be given. Until specific preventive measures are developed, potential susceptibles should be protected from all known predisposing factors which appear to play a role in the onset of the disease. Since the individual susceptible cannot be identified, all the children in a rheumatic family should be under medical supervision. In recessive inheritance eugenic principles are not applicable, unless perhaps in instances when both parents are rheumatic.

"If susceptibility to rheumatic fever is transmitted as a recessive character, the chance for each child (in a family or group of families) to be susceptible may be expressed as follows: If both parents are rheumatic, nearly every child will be susceptible. If one parent

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is rheumatic and the other parent is nonrheumatic but a carrier, i.e., rheumatic fever is present among the immediate family, each child has a 50 per cent chance to be susceptible. If neither parent is rheumatic but both parents are carriers, each child has a 25 per cent chance to be susceptible. (If at least one child is rheumatic, it may be assumed that the negative parents are carriers.) If one or both parents are negative, i.e., definitely known to be nonrheumatic and noncarrier, susceptible children would be unlikely.

"The preceding figures may be used to estimate the number of genetic susceptibles present in a family when the genetic constitution of the parents with respect to rheumatic fever is known. If at least one child is known to be rheumatic, the number of genetic susceptibles present in a series of such families may be estimated. Genetic factors have been established which facilitate computation of the number of susceptibles present. It is merely necessary to tabulate the series of families according to family size and multiply each group of families of given size by the appropriate genetic factor. These estimates may then be compared with the actual number of cases of rheumatic fever present in the series."

Dr. Wilson points out that it is generally believed that the incidence of the disease is lower in certain sections of the country and infrequent among children of the more favorable economic groups in all sections. She suggests that an estimation of the role of certain environmental factors might be obtained by using the family as the unit for genetic study, in which there would be utilized the mortality rates published by the Bureau of Census.

"Studies of potential rheumatic families in different geographic localities and diverse economic groups," she says, "should yield significant information as to the role of climate and environment in the development of rheumatic fever in susceptible individuals."

THERMOMETER SHOULD BE LEFT IN MOUTH A MINIMUM OF THREE MINUTES

Investigation has shown that a thermometer should be left in the mouth a minimum of three minutes in order to obtain the accurate temperature of the body, *The Journal of the American Medical Association* reports. It advises that in view of this manufacturers should eliminate time designations from their instruments. *The Journal* says:

"How long does it take a clinical thermometer to record body temperature accurately? The answer apparently is not known by all those who use this instrument of precision, according to N. DeNosquo, I. Kerlan, L. Knudsen and T. G. Klumpp. In order to learn what schools of nursing are teaching with respect to taking temperatures, a questionnaire was sent to one hundred outstanding schools. According to the replies, twenty-seven schools taught their students that the time required for accurate registration was less than three minutes, thirty-seven stated three minutes and only five recommended an interval longer than three minutes. Many clinical thermometers on the market bear such designations as '½ minute,' '1 minute' or '60 seconds,' which obviously suggests to the user that the time required to register body temperature is that inscribed on the instrument.

"The authors conducted a clinical and physical study to determine, first, how long it takes instruments of various makes and types to record body temperature and, second, whether or not there is any consistent difference between instruments bearing different time designations. On the basis of a series of observations, the validity of which was statistically controlled, the authors concluded that an insertion time of three minutes should be the minimum interval for oral clinical thermometers under ordinary conditions of use. It was also found by them that variations in the configuration of the bulb made no

appreciable difference in the time required to reach the final reading. Similarly the time stamped on the thermometer did not have any relation to the length of time required by the instrument to reach equilibrium, and in all circumstances a longer time was needed to give an accurate reading than that imprinted on the thermometer to give an accurate reading.

"In view of these observations it would seem to be a good thing for thermometer manufacturers to eliminate from their instruments time designations, which can only be misleading and result in serious diagnostic and therapeutic misimpressions.

"There is no instrument of precision that is more valuable in the diagnosis and prognosis of disease than the clinical thermometer. It is therefore essential that it be given sufficient time to record accurate information. There is a temptation these days to rush everything; but when it comes to taking temperatures it is the course of wisdom to make haste slowly."

EXPECTATION OF LIFE

"The League of Nations Monthly Bulletin for December presents tabular data on the expectation of life at birth and at one year of age in over thirty countries." *The Journal of the American Medical Association* for March 18 says, "For all countries covered the expectation of life at birth and in the earlier years of life is greater than in previous periods; the improvement is less striking or absent in later stages of life. The United States ranks high in the list and is exceeded only slightly by the Netherlands, New Zealand, Australia and Sweden. Japan, Russia and India have the lowest expectation of life, according to the latest information available. In all countries females show a longer expectation of life than males."

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report, March, 1944

DISEASES	Mar. 1944	Feb. 1944	Jan. 1944	Mar. 1943	Mar. 1942
Tuberculosis, Pulmonary	146	161	250	200	78
Tuberculosis, Other Forms.....	0	2	3	25	14
Chickenpox	661	629	387	442	503
Measles	1103	1135	1085	1356	401
Scarlet Fever	848	620	451	387	578
Smallpox	3	10	2	16	2
Paratyphoid Fever	2	0	0	0	0
Typhoid Fever	16	174	47	6	5
Whooping Cough	67	105	81	182	153
Diphtheria	33	37	61	20	34
Influenza	52	73	573	53	160
Pneumonia	40	46	80	78	116
Mumps	238	261	120	326	141
Poliomyelitis	1	2	6	0	3
Cerebrospinal Meningitis	37	39	65	26	2
Undulant Fever	5	9	2	1	2
Malaria	10	4	37	1	0
Infectious Jaundice	3	1	1	0	0
Erysipelas	1	0	0	1	0
Vincent's Angina	2	0	1	12	3
Rubella	14	10	65	898	61
Food Poisoning	1	2	6	0	0
Septic Sore Throat.....	23	3	0	0	0
Impetigo	2	3	3	0	0

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

JUNE, 1944

NUMBER 6

PRESENT-DAY EMPLOYMENT OF PHYSICALLY HANDICAPPED UNDER FEDERAL CIVIL SERVICE*

VERNE K. HARVEY, M.D.†

WASHINGTON, D.C.

The Federal Government is one of the largest single employers of civilian personnel in the world. Shortly after the attack on Pearl Harbor the United States Civil Service Commission, the central recruiting agency for the Federal Government, was faced with converting its examining and recruiting procedures to an all-out war basis. The Medical Division of the Commission, which services all the various functions of the Commission on medical problems, then undertook to convert relatively high physical standards for employment in both government industry and within the departmental service in Washington, D. C., to standards which would assure the maximum use of all available manpower.

Within a comparatively short period of time the Medical Division initiated extensive surveys of a large number of positions in government industry, including navy yards, arsenals, and air depots, for the purpose of determining the physical demands of these positions.

The scope of this undertaking can be judged by the fact that over one hundred governmental industrial establishments scattered throughout the continental United States were surveyed, and that in these establishments over 2500 titled positions, representing many thousands of different jobs, were carefully analyzed to determine the physical demands of the position in relation to functional and environmental factors.

I have indicated that one of our objectives in initiating these surveys was to assure the maximum utilization of manpower. This was, of course, an immediate objective; however, we realized at the time that later we would be faced with the problem

of absorbing our share of disabled veterans during and after the war.

The information which we have obtained as a result of the physical demands studies has been incorporated into a manual entitled *Operations Manual for Placement of the Physically Handicapped*. This manual has been widely distributed among appointing officials in the Federal Government and to state rehabilitation agencies, the Veterans Administration, the United States Veterans Employment Service and other cooperating agencies. It is an instrument for placement which enables us to match a handicapped person's disability along with his qualifications to positions in government industry. In effect, it has promoted a liberalization of physical requirements for appointment into the Federal service under the War Service Regulations. We are now able to encourage handicapped persons to apply for positions in the Federal service. The Commission announcements of examinations now carry a physical paragraph encouraging handicapped persons to apply for employment. We found, however, that this was not sufficient to insure the utilization of the relatively large untapped reservoir of handicapped persons, and that we must strengthen our working relationships with agencies primarily interested in the physically handicapped.

There are several federal and state organizations charged with the responsibility of looking out for the welfare of physically-handicapped persons. Among these are the Vocational Rehabilitation Service in the various states which operate under the guidance of the Federal Security Agency. The Veterans Employment Service, a part of the Bureau of Placement of the War Manpower Commission, is charged with the responsibility of facilitating the placement of veterans in suitable employment. Recently Congress enacted Public Law No. 16 which

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association, at Indianapolis, on April 20, 1944.

† Medical Director, United States Civil Service Commission, Washington, D.C.

established a veterans rehabilitation service within the Veterans Administration. This service is concerned with the rehabilitatory training of disabled veterans who have established a disability claim. In most states problems relating to rehabilitation of the blind have become the responsibility of special commissions for the blind. We have, therefore, two agencies, the Veterans Administration and the Veterans Employment Service of the War Manpower Commission, who are mainly interested in the welfare of the veterans. The State Rehabilitation Service and the Commissions for the Blind are mainly interested in rehabilitation of the non-veterans. However, disabled veterans who have not established disability claims are eligible for rehabilitation under the expanded programs of the State Rehabilitation Services. I am discussing the various rehabilitation services because they have played an important role in the Commission's program for maximum utilization of the physically handicapped. A coordinating committee, representing these agencies in addition to the Civil Service Commission, and the Council of Personnel Administration was approved by the Commission in October, 1942. Through this Committee the Commission has been able to establish working relationships which have developed the Commission's recruitment resources among the physically handicapped.

We have kept records of placements which have been made in the Federal Service, including those of physically-handicapped persons, since October, 1942. There have been recorded more than 26,000 judicious placements of physically-handicapped persons in the Federal Service. This indicates that they are being placed at a rate of about 1,500 a month. These placements have been in positions ranging from clerical to unskilled, semi-skilled, and skilled positions in heavy government industries. Among these placed are a large number of blind persons at air fields. Unusual placements have been reported, such as:

1. An armless telephone switchboard operator at a large government hospital.
2. A footless truck driver at an Army air base.
3. A one-armed auto mechanic (tire changer) employed in the motor pool in the Quartermaster Department at a Port of Embarkation.

The following table shows the number of handicapped persons placed in the field service of the Federal Government by types of disability from October 1, 1942, to April 1, 1944:

<i>Disability</i>	<i>Number Placed</i>
Orthopedic, including:	16,981
(1) Upper extremities	6,603
(2) Lower extremities	9,192
(3) Spinal column	1,186
Blind in one eye	4,750
Blind in both eyes	359
Hard of hearing	2,033
Deafness	799

Arrested tuberculosis	688
Organic heart disease fully compensated	2,017
Dwarfism	62
Total Disabilities	27,689
Total Placements	26,130

The emphasis in recruitment and placement is shifting toward the disabled veterans who already are being placed on the labor market in considerable numbers. The plans now are under way by the Federal service to absorb its share of disabled veterans during and after the present conflict. Our over-all objective will be to facilitate their placement wherever possible at their highest qualifications in positions suitable to them and satisfactory to the employer.

In meeting the large veteran problem after the war, the Commission must be ready to demonstrate to appointing officials, as a result of its experience in placing the handicapped during the war, that physically-handicapped persons who have been judiciously placed, as a whole, make efficient employees. We must be able to show what their personnel turnover, their production both in quality and in quantity, and their accident and absenteeism records have been in comparison with employees with all of their physical faculties.

With this in mind, the Commission's next step is to make a study of the manner in which the physically-handicapped employees have carried out their work. Our objective is clear. It has been demonstrated that specific jobs require specific abilities and faculties. We wish to discover whether persons with these abilities and faculties, even though they have permanent handicaps, are capable of doing just as effective a job as able-bodied workers. Why do we wish this information? First, to determine whether the program for the full utilization of handicapped workers should be given greater support and emphasis. Second, to determine what changes, if any, should be made in medical standards after the war, effecting the retention of and the employment of physically-handicapped workers. Third, to obtain useful information for all employing agencies on the efficiency of handicapped workers by types of disabilities. Fourth, to obtain information useful to the Commission in connection with the problems of placing disabled veterans during and after the war.

In getting factual material, comparing the rates of production, absenteeism, turnover, and accidents of the able-bodied doing the same kind of work as the physically handicapped, we will be in a position to render a greater service to the former government employee who has been disabled as a result of his service in the armed forces.

Several studies have been made contrasting the efficiency of handicapped workers with normal workers. The one most generally referred to was carried out by the Western Electric Company a few years ago. Four hundred eighty-two physically-disabled workers and 652 able-bodied workers were employed at the same time on the same jobs.

Careful records kept over a period of one year disclosed that the physically-handicapped workers had fewer accidents and fewer absences, and they all had satisfactory or superior production records.

A recent study was made by the Office of Vocational Rehabilitation, Federal Security Agency on the efficiency of physically-handicapped employees. Executives of large corporations engaged in manufacturing war materials were asked to submit reports showing how their physically-handicapped workers compared with their able-bodied workers in respect to absenteeism, labor turnover, accident rate and productivity. These reports showed the handicapped worker in a very favorable light.

At a time when our country needs *all* the services of *all* the people, physically-handicapped persons must be considered qualified for employment because of their abilities (and not disqualified because of their disabilities); however, our regional medical officers tell us that the greatest difficulty encountered in the program to utilize the services of the physically handicapped to the utmost is where medical and safety officers still maintain very rigid medical requirements. Why is this? Are they still operating under the misconception that handicapped workers are more susceptible to injury, based on the fear that injuries which would cause partial disability to normal workers may cause permanent total disability to workers already partially disabled?

The June 10, 1943, number of the *American Machinist* reported that a study of the employment records of a group of 4,404 men having orthopedic impairments disclosed that over a period of thirteen years only eight were reported to have incurred a second injury.

An executive in charge of the vocational rehabilitation program of one of our largest cities was asked the question: What have been the experiences of rehabilitation workers in the country with *second injuries*? He reported that the number of second injuries that result in total disability is very small—a small fraction of 1 per cent. Even so, there persists in the minds of employers the idea that the existence of disability makes the worker more susceptible to a second injury. Actually, the records show that physically-handicapped people who are intelligently placed in suitable jobs are the safest workers in the world. Even in the case of the totally blind who have been employed in industry for the past forty years, there has not yet been a major compensable accident in any of the many plants and factories in which they are employed. The reason is that the physically handicapped are more careful to obey safety regulations. In the words of the Ordnance Officer of the War Department at Fort Sill, Oklahoma, "Experience proves that accidents are much less with the already physically handicapped than with the able-bodied workmen because they apparently recognize their handicap and their loss, and have been made careful by this continuous reminder."

In order to take full advantage of the relatively

untapped source of desirable physically-handicapped employees, the Office of Chief of Ordnance, Safety and Security Branch, War Department, issued Circular No. 17, dealing with the utilization of handicapped workers. This circular urges the medical, personnel, and safety directors of each ordnance establishment to review their employment procedures and policy with a view of attempting to place every applicant for employment who is capable of productive effort at a job he or she can perform safely and efficiently.

When a second injury does occur, what relationship, if any, does it have to the permanent injury? This question was recently presented to the United States Employees Compensation Commission. They have analyzed 185 cases where a permanent injury occurred during Federal employment. In no instance did they find that a second injury was at all related to the permanent injury.

CONCLUSION

The fact that the field offices of the Commission have placed over 26,000 persons with permanent physical handicaps in Federal establishments since October, 1942, and that many more have been placed in private jobs by the United States Employment Service and by State Rehabilitation Agencies is abundant proof that handicapped workers can be used successfully in industry. However, appointing officers have not yet fully utilized to any great extent the reservoir of approximately two million physically-impaired workers available for war production employment.

Our country's greatest resource is its people. Yet in time of war we continue to be wasteful of our human resources by not using to the fullest extent possible this relatively untapped source to help overcome acute labor shortage. Every disabled person employed releases some able-bodied worker for the armed forces or for some job requiring all of one's faculties.

Our first step in attacking the problem was the job analysis study of 2,500 different positions. Our second step was to change our physical standards, based on knowledge of actual job requirements. Third, our *Operations Manual* was published and placed in the hands of Federal appointing officers and rehabilitation workers. Fourth, a committee for the recruitment, training, and placement of physically handicapped in the Federal service was created to establish more direct relationships between the agencies working with the handicapped and to coordinate their activities. The fifth step is a continuing one; the overcoming of the resistance and inertia on the part of employers to the employment of qualified handicapped workers and the convincing of appointing officers that there are many jobs in their agencies which can be adequately filled by physically-disabled persons.

As a part of this fifth step the commission has published a pocket-sized booklet, called *Untapped Manpower*. It was prepared especially to answer questions raised by appointing officers, such as the

following: (1) Why should we employ handicapped persons? (2) How do we know which jobs can be filled by disabled workers? (3) How do we match the qualifications of the applicant with the physical and environmental demands of the job? (4) How do we get handicapped workers? (Copies of the booklet, answering these and other questions, are available to those who are interested, and may be secured by writing to the central office of the Civil Service Commission.)

The sixth step is the controlled efficiency study of three thousand physically-handicapped persons who have been employed in the Federal Service for six months or longer. It would be shortsighted to encourage the employment of handicapped persons merely to help meet the manpower shortage. The study should provide facts which will result in

policies and programs that will contribute to the solution of problems directly affecting millions of disabled civilians and war veterans and indirectly affecting the economic well-being of millions of other citizens of this country.

A lot of boys in this war will come back crippled, blind or deaf. Some will come back with invisible wounds; by that I mean severe emotional disturbances referred to by some as war exhaustion, and by others as psychoneurosis. Let's give the former a chance to use their abilities and not disqualify them because of their disabilities. Let's give the latter a chance to readjust. Let's give them all the break they deserve for employment by an intelligent policy on physical standards so they can again take places in society as useful and gainfully-employed American citizens.

PUTTING THE VETERAN BACK TO WORK*

W. A. SMITH†

ANDERSON

Realizing the magnitude of the job which will confront us at the end of the war and how vital it is that it be handled properly, the Central Office of the General Motors Corporation, as well as its various divisions, has given a great deal of thought to the question of putting the veteran back to work, and in developing programs for this purpose. It is true that there are certain legal, contractual and moral obligations pertaining to the re-employment of disabled veterans who are physically able to perform their old jobs that make it incumbent upon industry to rehire them. This fact has been recognized and accepted by Congress, by society, and by industry. In our opinion, however, a program for the re-employment and rehabilitation of veterans, to be truly successful, must be based on more than the mere necessity of doing one's duty—that duty being imposed by law or public opinion. To be truly successful, a program must be based on a sincere desire to help these individuals return to normal civilian life—to help them reassume their responsibilities to their communities and families, and to train them, where possible, for better and higher-paying jobs where they will be self-supporting and independent. Our program at Delco-Remy is actually based on a desire to render assistance far beyond any requirements imposed upon us from any source, and it is for this reason that we believe it is fundamentally sound and that it will be successful.

We now have approximately five thousand employees on military leave, serving in all branches of

the armed services. It has been our practice to keep in constant touch with these individuals during the time they have been in service. Each one, in foreign service and in this country, is sent an occasional inspirational letter from our Personnel Director, and each week they receive a special military edition of our plant paper. On various occasions, such as Christmas and Easter, they receive gifts of candy, cigarettes, leather goods, or other remembrances of this nature. We have tried to let them know that they are wanted back on their old jobs when the war is over, to keep them cheered up and to build up their morale. Each week we receive literally hundreds of letters from them, not only those in this country but from all over the world. Every letter that asks a question or indicates that a reply is desired is answered. We feel this incoming mail is the best indication possible of the value of this program. Having maintained this very close contact with these employees, we are naturally most anxious that they shall receive proper treatment on their return to Delco-Remy.

As the first step in our program a committee was established to formulate policy and lay down procedures which were to be followed. This committee consists of the Director of Personnel, the Medical Director, the Safety Director, the Employment Manager, and a member of the Labor Relations Staff. In our case the member of the Labor Relations Staff was appointed to coordinate the activities of the group. The Committee first formulated the broad over-all policies under which we would function and three basic operating principles were evolved.

The first was that we would help veterans to help themselves in making the complicated readjustment

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association, at Indianapolis, on April 20, 1944.

† From the Delco-Remy Division, General Motors Corporation, Anderson, Indiana.

in the period of transition from military to civilian life. By this we mean that veterans will be given every possible assistance, sympathy, and consideration in helping them to get back into the normal swing of civilian life. However, it is not our intention to over-sympathize, coddle, or lead them by the hand. In our opinion such treatment will

with their sight or hearing impaired, or who have battle-incurred psychoneurosis—the group, in fact, to which we have the greatest moral responsibility, and the one, incidentally, which will put industry to the most severe test. As a general policy, we make every effort to place these handicapped veterans on jobs which they can perform without harm to them-

TRAINING OF INDUSTRIAL PHYSICIANS*

J. T. OLIPHANT, M.D.

President of the Indiana State Medical Association

FARMERSBURG

You have asked me to talk about the duty of the state medical society toward the training of industrial physicians. In a democratic body such as the Indiana State Medical Association, the question of what is its obligation in any given case might be a subject for prolonged and sometimes a heated debate. It is obvious that no single member has the right to speak for the entire body. Therefore, what I shall say here will express only my own individual opinion.

I believe that the state society should give every possible support to this movement of training men in industrial medicine. The rapid growth of industrialism and the mass migration of workers from the farm and from small individual enterprise to the factory has left our profession far from abreast of the medical problems presented by industrial employment. The present demand for trained physicians far exceeds the supply.

The further growth of industry, which most of us see ahead, will call for more and more doctors, so that industrial medicine is likely to become a profitable new field for specialists. Such a field would afford time and opportunity for its practitioners to study that great variety of ailments that we have come to know as industrial diseases. This study would benefit all doctors. It would give time and opportunity to trace the different patterns of accidents and to determine their cause, and thus prevent them. It would lead to better and more uniform methods of treatment of traumatic injuries, thus assuring the injured worker the minimal loss of time and the maximal restoration of function. Best of all, it would establish the industrial physician in a field of his own. He no longer would find it necessary or desirable to do all of the obstetrics, all of the practice of medicine, and all of the general surgery for all of the families of the workers under his care. This should lead to happier relations in the county medical societies, and thus redound to the benefit of the state society. These things are so important that we must support them.

There is another side to this question which is of so much interest that it should be mentioned here. This concerns the present method of employment of industrial physicians.

The present practice is for a plant or its insurance carrier to employ one or more physicians, according to the need, and to pay them either by a salary or on a fee basis or by a combination of the two, and to distribute the services of these doctors, when and as they are needed, to the workers in the plant. This arrangement violates two of the cardinal principles of free medical practice:

- (1) It interposes a third party between the doctor and his patient.
- (2) It does not give the patient the right to his own free choice of physician.

Our profession is engaged at this moment in a life and death struggle for the free practice of medicine. Our backs are against the wall. We are basing this fight on the principle of "free doctor-patient relationship." If we concede that it is right and proper for an industrial corporation to purchase medical services and to distribute them when and as it pleases, by the same logic we must concede that it is proper and right for a political corporation (the city, county, state, or the federal government) to likewise purchase medical services and distribute them to the citizens.

What is the obligation of the state society to this situation? I can express only my own opinion. I believe that unless there is some modification of this plan; that unless industrial physicians stop selling their services directly to a third party, we very soon shall find that all of us will be in the position in which Haman found himself. We shall be hanged to a very tall scaffold which we, ourselves, have erected in our own dooryard.

* Presented at the Second Annual Industrial Health Conference, at Indianapolis, on April 19, 1944.

simply lead to untold trouble in the future, as it develops in the individual the feeling that he is different from other people, entitled to special considerations, and that the world owes him a living.

The second principle pertains to the group who return with serious war-incurred disabilities. This group includes those with a leg or an arm missing,

selves or others. To be successful the placement of handicapped veterans must be on a sound basis, both from the standpoint of productivity and economic return to the worker. This means fitting the individual to a necessary job that is operating in the plant. Any attempt to "make work" for the handicapped man will not prove satisfactory either to the

individual or to the management. This does not preclude technological rearrangement of a job, and we contemplate and expect a considerable amount of it. It also does not preclude a reasonable break-in period during which time the supervisors must be most patient and careful in their handling of the veterans. There will be some cases of severe physical handicaps which will require extensive rehabilitation before employability can be restored. Congress has provided for vocational rehabilitation of disabled veterans under the direction of the Administrator of Veterans' Affairs. However, we will do everything possible to place our own employes on work they can perform and rely on the public rehabilitation facilities only when absolutely necessary.

The third principle established was that of the manner in which the actual re-employment in the plant would take place. There are two schools of thought on this subject. First, one group believes that the veteran should be set apart from the general group of employes. Under such a plan, special mechanics are established for every step of the re-employment procedure and their placement on jobs. For example, in some companies the veteran is greeted personally by the personnel director (or one of the executives of the department) and from that point throughout the various steps of re-employment he is carefully provided for by a special routine which sets him apart from other individuals. The veteran is made to feel that he is being given preferred treatment. The thought behind such an approach is, of course, that the feeling of strangeness on the part of the veteran will be lessened; that the transition from military to civilian life will be facilitated, and the readjustment period shortened. The second school of thought is that the veteran should, to all outward appearances, be treated as all other incoming employes. It is this policy which we have adopted. While each individual whom he contacts during the re-employment process is acquainted with the fact that he is a veteran and is, therefore, entitled to preferential consideration, little or no ado is made of his return as far as he personally knows. He is aware of a warm, friendly, and understanding attitude on the part of the people whom he contacts as he progresses through the steps of the program. He is, of course, conscious that he is somewhat different from the others because of the detailed information which he gives relative to his experiences in the armed services: questions as to his rank, battles, citations, special training—all of which are made a matter of record. But, as I have said, to all outward appearances he is put back to work with as little fanfare and trumpet blowing as is possible. This policy has proved to be very successful for us, and from discussions with perhaps a hundred or more veterans that have returned we feel that the great majority of them prefer to slip quietly back to their jobs and reassume their positions of civilian life. I will say further that this is the particular desire

of that group of veterans who have been discharged from military service because of some slight mental or physical impairment which made them unfit for life in the service. This principle, of course, ties in directly with our first basic principle of helping the veteran help himself—it does not set him apart as a different individual but permits him to immediately reassume his place in the plant on a normal basis.

After the basic policies had been established, there are two preliminary steps which we consider to be essential:

First, a survey is completed of all individuals now in our employ who were veterans of World War II. Detailed information is secured as to their length of service in the armed forces, battles in which they have been engaged, citations which have been received, reason for discharge, physical disabilities, and information as to any special training which they may have received while in the service. Such a survey is essential as it provides information for use in case studies and gives a record of all employes who have been in the service, precluding the possibility of difficulties which might arise through lack of this knowledge.

The second step is that of making a survey of all jobs in the plant and classifying them as to the type of work, physical strength required, dust, noise, temperature conditions, fatigue factors, and so forth. This survey is, of course, most essential as it will be the basis for job selection in the placement of the physically- or mentally-handicapped worker. We then established a procedure for the actual re-employment of returning veterans. Those veterans who are without physical or mental impairment are put through our regular employment procedure and assigned to their old jobs, or an assigned job if the veteran has never had previous employment with Delco-Remy. A special war veteran's card is completed on each one, giving detailed information as to his military experience, training, reason for discharge, et cetera. He is then given a medical examination by the plant physician and taken to his foreman in the regular manner. While it is not known to the employes, their personal history cards are so marked as to indicate that they are war veterans, and they carry a medical classification in code. (I will discuss our medical classifications a little later as they have an important bearing on our handling of veterans.)

Those veterans who return and will not be able to take up their old jobs because of some physical or mental impairment which is service-incurred follow a slightly different routine. They are taken immediately to the office of the plant physician where they are given a thorough physical examination and all the factors in connection with the particular individual are evaluated. Based upon this information the plant physician makes his recommendation as to the type of work the individual can perform and indicates conditions which must be avoided. These facts are then given to the representative of the Personnel Department handling veterans,

who, in cooperation with the Employment Manager and the Safety Director, using the survey as a basis for job selection, decide upon several jobs they feel the veteran can perform without harm to himself or others. The veteran is then given the opportunity of deciding which of the jobs in this group he feels he will be able to perform satisfactorily.

It is important that the veteran make the selection himself as he will approach his job with an entirely different attitude than if one is selected for him. He has made the decision, and being human he will make every effort to prove that he is right. As soon as his job is determined, he is then placed back in the regular routine procedure which is followed by all employees. The superintendent of the plant to which he is going is then called and acquainted with the full particulars of the case, so that when the veteran meets his foreman his case is thoroughly understood and he will be treated with patience and kindness. You may be sure that such cases are handled with greatest tact and finesse, and that getting back on the job is made as easy for them as is humanly possible.

The medical examination and classification by the plant physician is of greatest importance in the placement of the veteran. This is particularly true because of our inability to obtain detailed medical history from the armed services relating to the discharge. In many cases the information given to the veteran, as to the reason for his discharge, is entirely refuted by medical examination. It presents a particular problem with the psychoneurotics, as they are extremely difficult to spot, and, in cases where the reason for a discharge is given as nervousness or emotional instability the physician is without background for an accurate analysis of the seriousness of the mental disturbance.

As an illustration, we have the case of E. S.—thirty-one years old—married. He served ten months in the Army and was given a medical discharge for nervousness on February 20, 1944. He had spent two months in an Army hospital prior to being released. He hired in as a core assembler. After six weeks in the foundry, he found that his nervous condition was returning due to noise. Investigation proved that he had been of a nervous temperament before entering the service, and this condition had been accentuated by military training. He had applied for, and is currently receiving, 10 per cent disability benefits from the Government on this basis. We transferred him to a job where there is less noise, and he is doing satisfactory work. His medical classification has been changed so that he will be restricted to noise-free areas in the future. While no harm occurred in this case, if we could have had the benefit of the man's medical history this man could have been placed in a noise-free area immediately.

While it is supposedly possible to get this information upon the approval of the veteran through the medium of a signed waiver authorizing the

Government to turn it over to us, our experience has been that it takes so long to get it and that when it is obtained it is of such meager content as to be of little or no value. For our part, we have just about given up any attempt to secure medical histories and rely entirely upon our physicians.

As an example of our experience in this connection, I should like to tell you of the case of R. C. This veteran made application to us for employment, and his medical examination showed that he had a compression fracture of the dorsal spine. He also had symptoms of being psychoneurotic, and we felt it would be advisable to obtain his complete medical history before permanently assigning him to a specific job. We, therefore, wrote on December 21, 1943, to the Veterans' Administration Hospital and sent a waiver signed by the employee with our letter. The Veterans' Hospital replied, stating that they did not have any information concerning him. We then wrote (enclosing the waiver) to the Kennedy General Hospital at Memphis, Tennessee, where the veteran had been just prior to his discharge. They advised us that it would be necessary to communicate with the Surgeon General of the United States Army. On January fifteenth we addressed a communication to the Surgeon General and enclosed a waiver properly signed by the veteran. On February fourteenth (or almost a month later) we were informed that medical records of Army personnel were confidential War Department documents and the information therefrom is furnished only to the individual to whom the records pertain. They suggested that we have the former soldier send in for the information directly and they would furnish him with it. We did this and on April first we received a card from the Adjutant General's Office indicating that the information had been mailed direct to the veteran. In this case, therefore, we worked from December 21, 1943, to April 1, 1944, in order to secure the necessary information. If private industry is willing to assume responsibility for the rehabilitation of veterans, it would appear that a close cooperation between the Government and medical departments of the various industries would be very helpful.

The system of medical classification which we use is one developed by the General Motors Corporation, which we have adapted to our particular needs. As it is the framework upon which our entire program is built, I should like to cover it in detail. The veterans are classified in any one of five general groups:

GROUP I—Those who have no physical impairments and are able to resume their usual occupation or any other work in the plant. This group presents no particular problem from a rehabilitation standpoint and can be rehired in the regular routine manner.

GROUP II—Those who are still affected by some physical or mental condition which makes them unsuited for certain types of work, but who are able to perform other types of work efficiently. This group is divided into six classifications according to

their individual physical limitations. The purpose of the classification is to assist in proper placement and to provide a permanent record for the use of supervision as a guide in transfers which may be necessary.

Class 1—No hazardous machinery: This group consists primarily of individuals having serious visual defects, diabetes, heart disease, or hand and arm disabilities which increase the hazard when working with power machinery, such as rotary saws, punch presses, power trucks, cranes, et cetera.

Class 2—No heavy lifting: Individuals with various disabilities such as old back injuries, deformities, hernias, et cetera, are placed in this category.

Class 3—Ground-level work only: Individuals susceptible to vertigo from any cause, or having deformities or limitations of the extremities, should not be allowed on ladders, scaffolds, cranes, et cetera.

Class 4—Avoid dusts, fumes and skin irritants: Selected individuals with chronic bronchial conditions should be restricted from occupations such as dry grinding, sandblasting and spray painting. Individuals who are subsequently found to be sensitive to zinc chromate paint, cleaning solvents, and so forth, are placed in this class.

Class 5—No extensive walking or standing: Back lesions, varicose veins, lower extremity disability, artificial limbs, heart disease, and so on, fall in this category.

Class 6—Restrict to noise-free areas: Individuals with chronic ear conditions and partial deafness may have these conditions aggravated by exposure to sound levels of high intensity, such as that associated with airplane motors, speed hammers, riveting, band saws, horn testing, and so on.

GROUP III—Those who have a severe handicap which requires individual special attention for safe placement. This group presents the greatest problem. Based upon the physical condition and limitations of the individual and job requirements, the veteran's representative, the employment manager and safety director select several jobs which they feel the veteran can perform. The veteran is then permitted to make his selection from the jobs in the group.

An individual with a severe handicap is not likely to have the same confident mental attitude of the normal healthy person. He may doubt his ability to overcome his handicap. He may worry about his future security. This factor must be understood by supervisors and should be borne in mind by those who train and direct the work of the handicapped. Many of these cases require close follow-up to insure that the handicapped employe becomes acclimated to the work and becomes able to carry the full job within a reasonable break-in period. In several cases a shift to another job has been required. Illustrative of the problems in this group are the cases of R. E. G. and E. L. W.:

R. E. G.—married—twenty-two years old, served eighteen months in the Southwest Pacific as a sergeant in the Air Corps. He fell from the wing of a bomber which he was loading and severely injured his back. After several months in the hospital in Australia, his condition was improved and he was flown back to the United States and given a medical discharge. At the time he was reemployed, on December 13, 1943, he was still wearing a brace on his back. He could not go back to his old job as a stockchaser because of the lifting involved. He was given the choice of several jobs which we felt he could perform satisfactorily, and he chose file and burr. After a trial of one week he found that this was too strenuous, and he was given a job where he could sit down. This proved very satisfactory and he made rapid progress both on the job and physically. After a supplement medical examination on April first, it was found that his condition had been improved sufficiently to enable us to try him on a skilled job in maintenance, which will permit him to earn ten to fifteen per cent more per hour. His training (sheetmetal work in the Air Corps) had provided him with the necessary background and he is now doing very satisfactory work.

E. L. W.—twenty-nine years old—fifteen months service in the Air Force—five months' active overseas duty during which time he made eight trips over the continent—was credited with shooting down five enemy planes. He was injured when his plane crashed upon landing after the eighth mission. He fractured two vertebrae and was confined to the hospital for five-and-a-half months. He was returned to this country wearing a brace which held his head and neck in a rigid position. Upon his return, he was assigned to the General Motors Stage Production "Victory Review"—traveled throughout the country. When reemployed by us and returned to the regular routine of factory work, he was somewhat unhappy and there was some feeling on his part that he was entitled to a better job. His physical condition necessitated his being transferred from his old job on a lathe to a simple assembly job. During the period immediately following his reemployment, when he was somewhat depressed, we gave him time off when he requested it, and by being very patient and considerate have helped him to gradually return to a normal mental attitude. He is now doing satisfactory work.

GROUP IV—Those who are temporarily unable to work because of a physical condition. These cases will include contagious disease, unhealed tuberculosis, and other conditions from which the individual may fully recover with proper care without permanent disability. The Veterans Administration will be brought in on these cases. Actually there will be very few, as men will not be given medical discharges by the service unless they are completely recovered or well into the convalescent period. We had one of these cases just last week:

W. E. J., an employe who had been on military leave. After serving one year in the Army, he was given a medical discharge because of having contracted tuberculosis. Immediately upon his discharge on April 10th, 1944, he came to us for reemployment. Although his physical condition was not good and he did not feel like working, he was afraid he would lose his seniority if he did not return within the sixty-day period after discharge. At the time of his physical examination he was running a temperature and the x-ray lead us to believe that immediate placement was inadvisable. We waived the sixty-day period and sent the employe home for further rest. An appointment has been made for him to be examined by a tuberculosis specialist in May.

GROUP V—Those who require extensive vocational rehabilitation before they can perform any kind of work in the plant. In spite of all efforts to place returning disabled veterans, it can be expected that there will be some who can not be fitted to any necessary job that is operating in the plant without extensive vocational rehabilitation. In such cases the disabled veteran will be referred to the proper representative of the Veterans Administration to arrange for rehabilitation.

In these cases which comes under Groups IV and V we will follow through on the various steps with the Veterans Administration to help these individuals secure the things the Government does or will provide for them. We feel a continuing interest and obligation to these men, and when they do become sufficiently rehabilitated for employment in industry we will endeavor to use them.

The classification code is a matter of permanent record on the man's medical history card as well as in the department to which he is assigned. After the handicapped individuals have been placed, it is important that they not be moved to other essentially different jobs whose characteristics would be harmful to the individual's condition. When they are transferred to an essentially different type of occupation it is only upon the recommendation of the Medical Department and in most cases after supplemental placement examination by the plant physician.

After the veteran has been placed and returned to work, it is necessary that a regular routine be established for follow-up to see that he is getting along satisfactorily and is able to do the job. This, of course, is of vital importance in connection with those veterans who have some physical or mental disability. The individual assigned to this task talks with the veteran and with his foreman at regular intervals. We have found that it is often necessary to transfer the veteran one or more times to find the job to which he is best suited.

A part of our expressed objective, or ideal, is the training of veterans for higher-skilled and better-paid jobs. Much of this work will be accomplished through apprentice programs, and, for the continuation of the war, through our upgrading program which provides for the advancement of production

employees into the higher-skilled and higher-paying jobs in tool and die, maintenance and pattern work. There are many veterans returning, however, who have ambitions for advanced formal training in engineering. Some of these are young men whose schooling has been interrupted by entering the service. Others are those who while in the service have discovered hidden talents which they wish to develop—and still others who because of training received in the service have a desire for more extensive study. To provide for these veterans, the General Motors Institute, which regularly offers two- and four-year cooperative courses in engineering, has developed a special program. It consists of a two-semester pre-training or refresher course which is most flexible and for which no formal entrance requirements have been set. It is open to any veteran of good potentialities with the necessary foundation and ability. A man, depending upon his previous education and objective, may take one or two semesters, or in fact he may have part of his work in this program and part in the advanced work in the four-year Cooperative Engineering Course. Those who demonstrate the required capacity may go on to the regular four-year Cooperative Engineering Program, which gives a man the equivalent of a four-year engineering course in an accredited engineering college. It can be seen that in drawing up this program the governing factor has been in meeting the needs of the veteran.

We are at present engaged in a survey of over four hundred veterans currently employed, to determine which of them possess the proper qualifications for such training. An analysis has been completed as to their age and educational background, which includes special training while in the service. It has shown that approximately seventy of this group may have the necessary qualifications, and we are now interviewing these men and will offer those qualified the opportunity of this training which will better equip them for earning a living.

Our experience has shown that returning veterans fall in two general classes:

1. The group of individuals who because of battle-incurred disability have been discharged, and those who have been discharged because of some slight mental or physical disability which makes them unfit for service. In this latter group are those individuals who have some illness such as pneumonia, ulcers of the stomach, or injuries received in training. The rehabilitation of this group has not caused, and we do not believe will, much of a problem, and our experience to date has been good.

The case of E. W. L. illustrates this type: In the Army from September 5, 1940, to August 18, 1943, he served in North Africa in the Battle of El Guettar and Battle at Hill 609. He was partially paralyzed from shell burst on April 23, 1943, and suffered from shell shock. He was hired September 15, 1943, and placed on light assembly work—a

month later was transferred to a lathe. His work has been most satisfactory and his condition is improving steadily. He makes periodic trips to an Army hospital for checkup.

2. The second classification is that group of individuals who have been discharged because they are temperamentally unsuited for military service. This is the group who are emotionally unstable, and in the vast majority of these cases these characteristics were not acquired in the service but are inherent. It is extremely difficult to recognize this type upon their return because in many instances they have not been told themselves the real reason for discharge, and their discharge papers do not give us the necessary information. This is the type of individual who makes the most fuss about being a veteran; he demands preferential treatment; he has alleged back injuries and can not do any lifting; he has calcified glands in his chest and objects to working in any dusty environment; he has an alleged heart condition and must do extremely light work; or he has defective feet and must sit down. He is the "misfit" and generally you will find that he was a "misfit" in society before he entered the service. The problem with this type of individual was acute before the war, and now that he has the word "veteran" connected with him he represents even a greater problem, and is our greatest one to date. Actually they do not represent an authentic rehabilitation program any more than do those returning with ulcers, flat feet, hernias, or other non-service disabilities. Not only do they present a problem in proper placement, but they represent a very grave danger to the entire program unless carefully guarded against, because being constantly in the eyes of supervision they gradually will result in all veterans being considered in the same light.

Our thinking with regard to this group is that we do owe them a fair chance to a place in industry, and that we will go even further with them than we would with the ordinary employee. In other words, we are obligated to give them a reasonable opportunity, but their rehabilitation is not basically industry's responsibility; it is the responsibility of society as a whole. A good example of this type of individual is the case of E. M. A. He served seven months. Single—forty-six years old—was hired March 27, 1943, after discharge from the Marines at his own request to accept employment in an essential industry. On April 16, 1943, he reported to the medical department, complaining of vertigo and general nervousness—medical examination did not reveal any pathological condition. Discussion with his supervisors showed that he had been a constant source of trouble in his department. He wore his uniform (or parts of it) to work regularly, and talked to other employees about his having been in the service; therefore was entitled to special privileges. He was tried on a number of light assembly jobs, being given a much longer break-in period than is given regular employees. He was moved to another plant to give him a fresh start

under different supervision and a different type of work—all failed. This entire period was punctuated by frequent trips to the hospital. A complete investigation was then carried out, and it was found that before he went into the Marines the same conditions had existed—he had never done satisfactory work. In other words, we had on our hands a "misfit"—a man who had never been a normal individual before entering the service and who was using his few months of military service as a basis for holding his job. We finally have placed him as a sweeper, and he has been told quite frankly that if he does not do this job we can offer him nothing further.

Incidentally, this case is an example of another problem with which industry will be faced—that of pressure groups. At the time this man was transferred from inspection to janitor work, the union filed a grievance which said, in effect, that we were being unfair to this ex-marine in transferring him to a lower-paid classification—the inference being that here was a division of General Motors which was not taking care of a veteran. Such a grievance, though it has no basis in fact, is most dangerous and must be guarded against and avoided.

From industry's standpoint, when we contemplate putting the veterans back to work, we visualize 11,000,000 men in service with from 70 to 80 thousand being released monthly. Considering how many more cases of physical impairment there will likely be, and how much more serious the cases of battle fatigue are in this war than in the last, the problem may appear to be insurmountable and well nigh impossible of solution—actually it is not. The number of veterans who return with physical or mental impairment will be relatively small in relation to the total in service. Of this number, those who have extremely serious physical or mental impairment will be provided for by the government and will not be released unless capable of further rehabilitation; the remaining number can be adequately provided for if each industrial concern will do its part. It is not an impossible task. To date, in Anderson alone, we have reemployed 290 of our former employees who have returned from military leave and have hired 185 discharged veterans not previously employed by us, or a total of 475. Of this number 2 per cent have had overseas service and 3 per cent have service-incurred disabilities.

We have experienced some turnover in this group as a result of voluntary resignation on the part of the employee. Analysis of the group who have left shows that the great majority were individuals who had been with us only a short period of time before entering the armed service. They represent people in non-essential businesses who came to us for patriotic or other reasons. Upon their discharge they have come back and worked until such time as an opening developed in their previous line. Despite the acute shortage of labor, we have not attempted to hold these individuals, but have permitted them to return to their old occupations because we felt that if the veteran is more contented

in some other field he should be permitted to go to it, and at the same time it makes it possible for more veterans to be placed on our payrolls.

In conclusion, let me say that we at Delco-Remy are not discouraged by the magnitude of this job of putting the veteran back to work. We are confident it can be done. It will take a lot of planning, a great deal of ingenuity, much patience, and real teamwork; but in the final analysis it resolves itself to simply handling each case on an individual basis,

evaluating all of the factors in the man, taking into consideration capabilities as well as limitations, assisting him to choose the work which he will be able to do best in order that he may be a self-sustaining member of society for the balance of his productive life, checking on him periodically to see that he is getting along satisfactorily, giving him the opportunity to train for better jobs, doing all this without emotionalism or paternalism—helping him to help himself.

A PRACTICAL PROGRAM FOR HUMAN REHABILITATION*

HAROLD A. VONACHEN, M.D.†

PEORIA, ILLINOIS

The return of the physically handicapped from military to civilian life presents a problem which will test American ingenuity equally as much as its economic and political problems. Unless a well-organized program is prepared in advance, we will be faced with returning disabled men being forced to wait for jobs, with each day's delay increasing his resentment, his mental depression, and his thought that he might be dependent upon charity.

About eighteen months ago, Caterpillar realized that four to five thousand employees would return after the war, with many of them suffering from physical handicaps. In facing this problem the company could draw upon their many years of experience in the rehabilitation of their own physically handicapped. This, plus a shortage of manpower, presented the possibility of unifying our programs for the civilian and military handicapped people. Steps were taken for its formation, with close cooperation between Medical, Personnel, Training and Safety Divisions.

It was first necessary to determine the jobs available for these individuals, and a survey was made

in which each supervisor listed the jobs in his department which could be performed by employees with the handicaps listed on the survey cards. With this information, the Personnel Division, with its knowledge of "job analysis," was ready to interview the individuals and then present the applicant to the Medical Division for its approval of the specific job chosen. A personal interview followed, impressing upon the employee the necessity for care and safety in his work, and a note was placed upon his record card that no transfer could be made without the consent of the Medical Division.

Supervision and training now appears in the picture. Supervisors were instructed in the proper handling of these people, and the "Job Instructor Training" given job trainers. That supervisors have given their complete approval, there can be no doubt, for almost daily they are asking for more handicapped employees. They are continuously finding new jobs, and several supervisors have learned the sign language in order that they might converse with their deaf mutes. Many of our employees with physical handicaps are attending special classes given by our training school in order that they may advance in their quest of independence.

There can be no doubt that this program has been successful, for the vast majority of these



He Wears the Purple Heart

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association, at Indianapolis, on April 20, 1944.

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people have a production, safety and absentee record above normal. They are paid the same rate as normal individuals; they are shown no special favors and are in no way considered as accepting charity. They will be given the same consideration as any other employee in being retained on the job in the days following the war.

It might be well to consider here the classification of the handicapped. Some employers list on their payroll many thousands of physically-handicapped people, but they include in the group employees with hernias, loss of fingers, slight defects in vision, hay fever, et cetera. In Caterpillar's handicapped group are only those with the loss of one or both extremities, marked deformities, loss of one or both eyes, loss of hearing and speech, and those with healed tuberculosis, heart disease, et cetera. The classification, after all, is unimportant except that some uniform plan would help in the formation of a nation-wide program.

At present Caterpillar has approximately eight hundred such handicapped employees, and this number is remarkable when consideration is given to the fact that it builds heavy machinery, calling for heavy and light machine work, similar types of assembling and grey iron and aluminum foundry work.

State compensation laws must be considered, and some changes would relieve the employer of carrying all the risk. Steps are now being taken in order to overcome this objection, in order that more of those with handicaps will be able to obtain gainful occupations.

Those suffering from nervous disorders, return-

ing from military service, will present a problem of some magnitude, but certainly many of these individuals will recover if we are able to quickly absorb them into an occupation which will convince them that they are fully capable of caring for themselves and their dependents. Days of calling upon one employer after another, weeks of disappointment and indecision will only aggravate their condition, forcing them to accept any aid available for their livelihood. Many cases of this type will require special medical care and vocational training.

After Caterpillar assured itself of the success of this program in its plant, it felt that the plan should be carried forward to the community. The idea was offered to the Peoria Manufacturing Association, and from this came "The Peoria Plan for Human Rehabilitation—Civilian and Military" which we believe is the first to be established in a community with a complete working organization. This plan is unique because the many employers in the Peoria area were organized and made ready to accept the physically handicapped. Usually, the intake groups are forced to approach industries and other employers with a plea for opportunities for the persons with physical handicaps.

The Peoria Plan consists of an executive committee with representatives of all the interested groups in the community; American Legion, disabled American veterans, mothers and fathers service clubs, manufacturing groups, retailers, unions, Junior Chamber of Commerce, associations of commerce, ministerial association, Catholic



*War veteran
returns to
work*

*Courtesy of
Dr. H. A. Vonachen*

priests, Red Cross, schools, mothers' clubs, farm bureau, federal, state, county and city agencies.

Sub-committees were formed, and now an office is being equipped—clerical help being donated by the Red Cross and a counselor being employed who will first investigate cases and then confer with a steering committee which will place each returned man in the proper classification for immediate or eventual employment.

In conclusion let us briefly summarize the outstanding points of this program:

1. Now is the time to organize—do not wait until the disabled veterans return from the war.
2. A well-organized program in each company is necessary for success. In many organizations this consists of close cooperation between medical, personnel, training and safety divisions, and supervisors.
3. A survey of jobs is essential.
4. Employers of small groups can participate because of first-hand knowledge of their jobs.

5. The production, safety and absentee record of the physically handicapped is above average.
6. State compensation laws could be changed to benefit the program.
7. Classification of handicapped individuals should be clarified.
8. "War neurosis" cases will benefit from quick employment with special attention given to individual cases.
9. We recommend to other communities their sincere consideration of "The Peoria Plan" (a booklet describing this plan is now being prepared).

"The Peoria Plan" for human rehabilitation is a fine humanitarian program which gives to every individual the opportunity to receive his "God-given Rights" to care for himself and his dependents. Above all, it demonstrates the willingness of all concerned to contribute their share in making the United States of America the outstanding example of true democracy.

DESCRIBES DEPOSITION OF IRON IN THE LUNGS OF ELECTRIC ARC WELDERS

Siderosis of welding is described in the *Journal of Industrial Hygiene and Toxicology* for March, 1944, by O. A. Sander, M.D., of Milwaukee, Wisconsin, in a final report of cases under observation since 1935. Five detailed case reports are presented showing x-ray changes simulating silicosis.

"Out of approximately 500 welders' films we have seen, the incidence of nodular shadows was less than five per cent," Dr. Sander points out. Because of this we had concluded that deposition of iron pigment would not occur to a visible degree when the work was not confined.

"As to the diagnosis and terminology to be used for these lung changes, they almost invariably are mislabeled 'silicosis,' 'atypical silicosis,' and even 'military tuberculosis' when first seen by roentgenologists and general physicians. This is understandable when one realizes how recently the pathology first became recognized and how closely the x-ray appearance resembles silicosis. These iron deposits may properly be diagnosed as 'siderosis' provided the concept of fibrous tissue proliferation is excluded. Because of the erroneous implication of associated fibrosis with any of the '-oses,' it has been suggested that it would be safe to simply call this change 'iron pneumoconiosis,' which carries the same objectionable implication of fibrous proliferation. My personal preference is to name it 'siderosis of welding' and to emphasize and re-emphasize that there is no fibrous tissue proliferation associated with iron deposits alone or associated with welding alone.

"As far as other evidence of lung irritation is concerned, we have not found any remarkable degree of bronchitis in welders generally, including those who obviously have had intense fume exposures. Nor have the many welders we have interviewed had such complaints as severe cough following confined work, nausea and vomiting, blood spitting, hoarseness, difficulty in breathing, chest pain, et cetera, as have been ascribed to welding by a few investigators. We never have heard of a case of pulmonary edema or 'welder's pneumonia' in our district. Reports from numerous shipyards have indicated that a number of cases of acute irritation of the throat, with cough, bloody sputum and hoarseness have been found, which have cleared up promptly after a few days away

from excessive fume concentrations. Too often, however, local physicians have advised such patients to discontinue their trade altogether, which seems unwarranted on the basis of the known data and experience.

"It should not be inferred from these statements that we feel that all welding is entirely innocuous as far as effect on the lungs is concerned. Quite the opposite, we know that exposure to highly concentrated fumes may be definitely harmful under certain circumstances, especially when they contain appreciable amounts of irritant substances, and certainly it is anything but pleasant for anyone to be working in dense clouds of any fumes for prolonged periods of time. Every effort should be made to dilute all fumes before they are inhaled, either by adequate and properly placed ventilators or by the use of ventilated helmets or positive pressure respirators. The prevention of siderosis and the acute respiratory reactions can be accomplished without too much difficulty or expense, and it is recommended that active preventive measures be taken when a suspected hazard exists."

In summary, Doctor Sander states that siderosis can occur within a period of six to ten years if the welding is done in an enclosed space. The siderosis so produced is an inert deposition of iron pigment in the lymphatics and is without fibrous tissue proliferation. Further siderosis does not predispose to tuberculosis or cause a functional impairment of the lungs.

This same subject was discussed by Doctor Sander before the Second Indiana State Medical Association's Conference on Industrial Health, held at Indianapolis on April 20, 1944.



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OBLIGATIONS OF THE UNIVERSITY IN TRAINING INDUSTRIAL PHYSICIANS*

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Dean, Indiana University School of Medicine

INDIANAPOLIS

What does the industrial physician need to know? What clinical training does he require?

The function of the industrial physician is to preserve the health and efficiency of workers. His activities must extend far beyond the limits of the factory. The efficiency of the worker often depends more on his mental than on his physical condition. If he is not comfortably housed, or has family troubles, or troubles with the management of the plant, or with labor organizations his efficiency as a worker will be impaired. The extent to which industrial physicians must deal with these economic and sociologic problems of the worker will vary, but he should have a good knowledge of them and a good practical training in dealing with them. He also needs to know about sanitation, housing, and various other community problems.

I think that you will all agree that well-trained industrial physicians should have the following knowledge:

1. All that we expect a competent general practitioner to know. This is a great deal, because we expect him to know something about every branch of medicine. He needs to know a great deal about psychiatry, dermatology, venereal diseases, traumatic surgery, radiology, and many other subjects. An industrial surgeon must be versatile, diplomatic, able to meet any emergency, open-minded, progressive, and adaptable to the rapid changes characteristic of modern industry.
2. The most advanced practices to safeguard the workers from injuries of all kinds, including the effects of poisonous liquids and gases, and the effects of overwork, poor ventilation, and improper lighting.
3. A knowledge of modern public-health measures—sanitation, housing, sewage disposal, and dietetics, including the care, preparation, and serving of food, epidemiology, et cetera.
4. What we expect a company attorney to know about industrial organization, the organization of labor unions, about unemployment insurance, health insurance, and the laws governing industrial compensation.

Only a small part of this training can be given as undergraduate work. The medical school curriculum is already overloaded. All medical educators now agree that specialized training demands postgraduate work. Industrial medicine is already well established as a specialty. We should train men for it on the well-tested plan for the training of specialists in other branches of medicine.

The training, which I think the specialist in industrial medicine should have, consists of the following:

1. *The undergraduate course.* This is designed to give the student a working knowledge of the basic sciences and a general acquaintance with the entire field of medicine. At graduation he has a general knowledge of modern methods of diagnosis, prognosis, and treatment. He should, also, be able to think for himself.
2. *A rotating hospital internship of one year's duration.* This gives the student an indispensable training in the application of the knowledge he has already acquired in the management of patients. It also gives him valuable experience in dealing with relatives of patients and members of the hospital staff. The internship is designed to make the student a good physician.
3. *A course, two to three years in length, in a school of public health.* Here, he would receive instruction in industrial engineering, sanitation, epidemiology, et cetera. A considerable part of this training should, in my opinion, be clinical in nature. The students should be assigned to duty on the health departments of industrial organizations which have well-organized and approved medical departments. At the end of this period of training the student should be required to pass a National Board Examination, just as a physician who wishes to qualify as a surgeon must pass a national examination. He would then be certified as a qualified specialist in industrial medicine.

You may be interested to know that the Indiana University School of Medicine has under consideration the establishment, in conjunction with the Indiana State Board of Health, a school of public health. The facilities here available are ample for giving the above-outlined course of instruction. We have on the medical school campus the administrative offices and the laboratories of the Indiana State Board of Health. We are situated in a great industrial center, and other great industrial centers are within a short distance. The medical departments of these industrial plants will, I am sure, readily grant residencies in industrial medicine to students who seek them.

CONCLUSION

Industrial medicine is already emerging as a specialty. A competent industrial physician needs the training which we require for every good doctor. He also needs good special training in public health and in the special problems which he must meet in dealing with the industrial worker and his family. This special training he should get in a school of public health and as a resident physician with the medical departments of industrial plants.

* Presented before the Second Annual Health Conference of the Indiana State Medical Association, at Indianapolis, on April 19, 1944.

DISABILITY EVALUATION*

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Disability evaluation is the establishment of the lessened degree to which a man may perform work as a consequence of physical injury. The necessity of establishing such evaluations is more frequently encountered in the procedure of satisfying claims before industrial courts and pension boards. Since the medical profession is responsible to such bodies for all medical facts and opinions, the subject of disability evaluation is one worthy of full study and discussion from every angle.

DISABILITY AS A SOCIAL SECURITY PROBLEM

No plan has yet been devised which would establish accurately the economic loss to disabled individuals. In light of social security thinking, the underlying principle of compensation to a person who has suffered a disability is to assure him of the substantial economic independence of an earning capacity. Protection is provided against unusual risks of occupation or military activity in that those who suffer injury or disability may not be left dependent upon charity or relief if they can be given opportunity to remain economically independent despite a loss of earning capacity. It seems that the more satisfactory method of extending compensation or pension benefits is through the schedule plan. That is, statutory benefits are applied to actual losses through a schedule of losses by amputation at certain levels of the limb, or through total loss of limbs, sight, or hearing. There are as many variations in schedules as there are domains which have compensation and pension laws. Nevertheless, there is a certain uniformity of purpose to all such laws which creates an average measurement of various degrees of disablement. Most schedules specify certain values on individual limbs, fingers or toes. Others, such as the United States Veterans schedule, establishes a loss of any part of the limb or body as a percentage loss to the body as a whole.

EARNING CAPACITY vs. DISABILITY EVALUATION

(Basis of Compensation to the Disabled in General)

There are two principal factors which seem to operate in determining the decisions of compensation and pension courts:

1. Loss of earning capacity.
2. Economic or social need of the disabled workman or his dependents.

In arriving at conclusions as to the loss of earning capacity, the court must have medical opinion as to the extent of injury and extent of disability.

It should be kept clearly in mind that the court is dealing with the earning capacity feature of disability, and that medical opinion is for the purpose of enabling the court to reach a fair decision. What does a doctor know about the earning capacity of an individual? Even the industrial court cannot judge too efficiently in this respect, and for this reason the statutory schedules of specific awards were included in the compensation laws to create a fair average. Most compensation laws use ordinary manual labor as the test for capacity to work. In other instances the test may be the occupation at which the man was employed when injured. The answer as to loss of earning capacity from disability might vary greatly between these two criteria. The medical expert should hardly be expected to give a competent answer because such a basis of evaluating disability is a test of occupational efficiency, and few doctors have ever worked sufficiently at any occupation outside of his profession to be expert in knowing the qualifications of such occupations. The wage loss of earning capacity, furthermore, depends on the workman's readaptability, which in turn depends on age, skill, mental judgment and willingness to try.

THE STATUS OF THE MEDICAL WITNESS

Since it falls to the lot of the medically-trained witness to render reliable opinions which will enable the court to adjudicate the losses and to assess the awards, it must be fully realized that he is but a part of the trial of the case. He need not become too excited and worry too much about the importance of his personal testimony. Through the well-established trial system of court procedure the attorneys on both sides of the case try to augment or minimize the evidence recited by the medical experts as may favor the interest of their client. The doctor is on examination when he appears before the court. Thus, questions and cross questions may seem to lead to mixed-up answers. Scientific deductions may be discredited by sly inference, but all is a part of the trial method of bringing out the facts. If the doctor is competent and has told the scientific truth as he sees it, that is his full duty. If he thought he had told the truth but was not certain of being right or wrong, then his sincerity of purpose will take care of his future reputation.

STANDARDIZATION A NECESSITY

It is vitally important to the integrity of the medical profession that there should be some standardizations agreed upon relative to the subject of disability evaluation. The steps and processes of mental reasoning on the subject should be stabil-

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ized, and methods of arriving at conclusions should be systemized. Medical men could not be expected to agree entirely on the final answers, but they are expected and accustomed to reaching a scientific conclusion by means of analytic reasoning. For example, if three physicians are called into consultation, first of all they will more than likely be chosen because of their reputations as specialists; second, they will follow a uniform pattern of investigation; and third, they will reach a conclusion based on clinical findings and not guess at it. Yet, each may reach a different conclusion as to diagnosis. One may say typhoid, another pneumonia, and still another appendicitis—yet it will not be to the discredit of any of the three to be wrong. On the contrary, in disability evaluation, if three physicians are selected to examine and testify in a case, each is likely to be chosen because of his reputation for a high, low, or conservative evaluation, and not especially because of his high professional attainments.

AN OUTLINE OF DIAGNOSTIC STEPS IN DISABILITY

The following points should be respected in dealing with disability cases:

1. The history should be stripped from weighted influences intended to impress the examiner.
2. The subjective complaints should be verified or disproved by physical findings.
3. X-ray and laboratory examinations must be reliably interpreted. Overemphasis of x-ray shadows should be omitted.
4. The anatomic loss to the parts of the body, such as deformities and shortening, must be accurately considered as to seriousness.
5. The examiner should have some knowledge of physics and geometry to interpret the physiologic effect on the arms and legs of static deformities and altered mechanical forces caused by injury.
6. The ability of the body to readjust to deformity must be considered. Individuals vary greatly in response to rehabilitation forces.

EVALUATION OF THE PERCENTAGE OF DISABILITY

In order to evaluate disability in terms of percentage, as is so often requested, it is necessary for the physician to formulate some definite measuring rod ruled with fundamental factors which constitute function and ability to work. For several years the author has been advocating a standard of measurement based on the percentage value of the various factors which promote function. In manual labor, whatever the specific work may be, the following functions are essential: walking, climbing, jumping, balancing, bending, reaching, pushing, pulling, grasping, holding, throwing, pinching, and twisting. In carrying out such activities certain qualities of attainment are necessary. These may be summarized into seven distinct factors or units, each of which has a respective

value in relation to 100 per cent normal function, as follows:

1. Quickness of action	10 per cent
2. Coordination of movement	20 per cent
3. Strength of effort	20 per cent
4. Security and confidence	10 per cent
5. Endurance of activity	20 per cent
6. Safety as a workman	10 per cent
7. Prestige of normal physique in securing employment	10 per cent
Total	100 per cent

In applying these units of quality in function, the human element and the influences of social environment must be considered, as well as the mere working capacity. The possibilities of rehabilitation, surgical improvement, social limitations, age, intellectual aspirations or opportunities, and the suitability to readaptation of working effort should be considered. When this is done, the disability may be expressed in percentage by applying the measuring rod of the seven functional factors.

For example, let us take an injured knee which has resulted in loss of motion. The number of degrees of restricted motion is not necessarily indicative of the extent of disability. If the knee can reach full extension but is otherwise limited in movement, the disability is much less in proportion than a knee that is limited to a right angle in extension but has a good range of flexion. After giving full consideration to analysis of the case, conclusions as to percentage of loss of each function factor may be approximately as follows:

1. Delayed Action and nimbleness 35 per cent. 35% of 10 (value of quickness factor)	3.5
2. Awkwardness and loss of coordination 35 per cent. 35% of 20 (value of coordination factor)	7.0
3. Weakness 25 per cent. 25% of 20 (value of strength factor)	5.0
4. Insecurity and lack of confidence 25 per cent. 25% of 10 (value of security factor)	2.5
5. Diminished endurance 40 per cent. 40% of 20 (value of endurance factor)	8.0
6. Increased risk to self and others 35 per cent. 35% of 10 (value of safety factor)	3.5
7. Adverse influence to employment 25 per cent. 25% of 10 (value of physique factor)	2.5
Total percentage of disability	32.0

SUMMARY

Such a system has great advantages because it can be applied toward any objective base of physical effort. It establishes a reasonable basis for physicians to meet on a common ground or starting point.

VALUE OF INDUSTRIAL MEDICAL SERVICE IN INDUSTRY*

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NEW YORK CITY

There are two important phases connected with the effort to bring about better medical service in industry. One concerns the proving to the industrialist that a good medical service is necessary as well as profitable, and the other is to convince the medical profession that special training and experience are required to fit the doctor to perform a worth-while service for industry under conditions that will not interfere with but will help in the production of the particular product that it manufactures. Indiana is rendering outstanding service in both phases of the subject. The Industrial Health Conference last year and this second conference have provided information and directed attention to the sources from which doctors can obtain the needed knowledge to meet the requirements of industry. It has also brought to the attention of management the need for and the advantages of an adequate medical service.

It is generally agreed that on the whole the medical service in large industries has been good, but the large plants employ scarcely half of the industrial workers. Of the thirty million estimated persons engaged in industry, over half are employed in plants that have five hundred or less workers, and the great majority of these do not have a medical service worthy of the name. It is to this latter problem that the National Association of Manufacturers has particularly directed its attention. Much educational work has been done, based on actual surveys. It has been shown that where the factors entering into the situation are more or less the same, the accident rate is much lower in a plant that has a proper medical service. A survey based on 2,064 plants with 1,945,551 workers showed that in plants having a good medical service, there was a reduction of 62 per cent in occupational disease; 44 per cent in accidents; 29 per cent in absenteeism; 28 per cent in compensation; and 27 per cent in labor turnover.

In factories employing five hundred workers, an actual saving of \$5,000 a year is possible by installing good medical protection. Here then we have proof that medical service in industry is not only humanitarian but that it is good business. The financial rewards are probably greater in many plants than the foregoing figures indicate. For instance, in one plant, after introducing the use of protective goggles, the direct cost of eye injuries in one year was reduced from \$51,000 to \$5,800. In a small plant the cost dropped from \$2,000 per year

to \$50. Such experiences can be multiplied over and over. There also remain the important factors of good will, improved morale, less spoilage, more willing workers, and the greater achievement that is possible by healthy workers.

As a matter of policy, the major effort of the National Association of Manufacturers in the field of health has been devoted to stimulating the creation of medical service in plants that are without it, with special emphasis on medical service for small plants. At times, however, a special activity is so important that participation is imperative. A case of this kind is in the field of nutrition. It is generally agreed that one of the most promising roads in the further control of disease lies in this field. There have been great strides in the past, but equally great ones are in prospect. Heretofore, we have relied largely upon the control of animal parasites. Now a new approach beckons. Adequate nutrition has already brought about amazing improvement in health and well being. From authoritative surveys, it must be recognized that probably fewer than one-third of the industrial workers have adequate diets. In one airplane factory, among its workers there was a deficiency of 48 per cent in Vitamin A; 21 per cent in Vitamin B-1; and 42 per cent in Vitamin C.

Far too often we forget that the human body is a machine that is in constant need of repair after it creates power, energy, cerebration and heat. The worn-out parts need the same kind of materials for reconstruction of which they were originally formed. No good workman would expect a machine to function satisfactorily if he repaired a part of tempered steel with wood or retreaded a tire with cotton tape. Just so it is with the human body. Unless our foods contain the essential substance to make repairs, a proper functioning machine cannot be expected. Science has clearly demonstrated that the protective foods contain all the essential things needed to create energy, to make repairs, and to keep the human machine in order. The protective foods that should be in everybody's diet every day are: milk, eggs or meat, leafy vegetables, whole wheat or enriched bread, and citrus fruit.

In order to motivate the establishment of more adequate eating facilities in industry, the president of the National Association of Manufacturers addressed a special letter to its entire membership. The improvement that was to be expected in the morale and in the production and labor relations among workers adequately fed was emphasized, and that the difference between success and failure in operating in-plant feeding establishments depended

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association, at Indianapolis, on April 19, 1944.

† Consultant to Committee on Industrial Health of the National Association of Manufacturers.

upon expert planning and administration. This presentation aroused much interest among the 10,000 executives to whom it was addressed, and many inquiries were received for detailed information. Fortunately, that was available in the excellent publications issued by the government, insurance companies, and other sources. In addition, the government, through its regional offices, made available the services of experts to help industry in making plans to improve or to establish new restaurants. Recently the War Food Administration stated that priorities for industrial food equipment could be promptly obtained on proper application. For those who did not wish to enable themselves of government assistance, the National Association of Manufacturers supplied a list of private caterers who were in a position to set up feeding facilities along lines adapted to any type of industry. One of these firms that came to my attention now supervises the feeding of over 750,000 workers daily. Nutritionists, engineers, and other technical personnel are employed in setting up adequate eating facilities as well as to conduct a sustained educational effort. The outlook in the future for sensible feeding in all restaurants, both industrial and non-industrial, is indeed encouraging. In the Pentagon Building, in Washington, is operated the largest restaurant in the world. Among its features is an experimental kitchen in which research is directed to find appetizing ways to serve the foods that are essential to the human body. Many restaurant operators avail themselves of the knowledge developed in this experimental kitchen.

The government, in its effort to improve the diet in the restaurants and cafeterias which it operates in ordnance plants, shipyards and schools, has utilized volunteers from the restaurant business to visit these places and make suggestions for improving the quality of the food and the service. Many of the volunteers apply the knowledge which they have acquired in the Pentagon experiment to their government work as well as in their own restaurants.

Another most important activity the National Association of Manufacturers has undertaken on a large scale is to help industries solve the problem of the reemployment of handicapped workers. The law of the land requires, whenever possible, the reinstatement of all veterans by their former employers in a "position of like seniority, status and pay" who apply within forty days after their discharge from the armed forces.

On the ground that it may handicap the veteran seeking employment in competition with the non-veteran, it is the policy of the government not to make available to industry his medical record. A medical examination will, no doubt, reveal a large number of borderline cases. For instance, it has been stated that of the first million men who have been discharged from the military forces, 300,000 have some form of psycho-

neurosis. In addition, from 10 to 15 per cent have been rejected for this reason at the induction centers. In some combat areas as high as 70 per cent of the participants emerged with a neurosis. The employment of these men is a medical problem of larger proportions than has ever been faced by industry. It is a reasonably safe assumption that the vast majority of them are not sufficiently handicapped to prevent their finding employment, but there will be many that may not be able to work with safety to themselves or to others. It will be apparent, therefore, that the entire number should be examined if the unfit are to be discovered and their lives safeguarded. This is a huge task. It is well known that a proper mental examination is tedious and requires much more time than is ordinarily available to industrial health practice. American industry, by its vast-scale production of war materials, has once more proved its amazing efficiency in dealing successfully with large-scale projects. Undaunted by this tremendous new demand, industry already is arranging for not only medical examinations but also for placing those who are physically handicapped in suitable jobs.

To work with the National Association of Manufacturers Medical Advisory Committee, under the chairmanship of Dr. W. Irving Clark, a number of psychiatrists have been named. This committee is preparing a memorandum which it is hoped will enable the industrial physician to make a suitable examination within a period of time that is practical under industrial conditions.

The psychiatric group will also serve in an advisory capacity to the nation-wide committee of Veteran Employment Problems, appointed by the National Association of Manufacturers.

A recent test survey showed that already many industries have made suitable provision and are employing handicapped persons. A study of the problem has revealed that much of the apprehension heretofore felt in placing handicapped persons has been groundless, and in some respects they have advantages over the physically sound. In some plants absenteeism is less among them, and they are found to be, on the whole, efficient workers and not so liable to accidents as those who are robust physical specimens who by their very vitality take risks from which others would refrain.

Industry, in the employment of veterans, proposes to go beyond its legal obligations, as may be seen from the following outline:

"The procedure for dealing with handicapped or disabled veterans will deal, in great detail, with:

- (a) Survey of potential jobs for which disabled veterans can qualify.
- (b) Determining their physical and mental abilities and limitations.
- (c) Determining suitable jobs.
- (d) Training or re-training veterans for specific jobs.
- (e) Foremen's role in facilitating the dis-

abled or handicapped veterans' adjustment to the job.

(f) Follow-up by personnel department."

In the creation of new products, particularly in wartime, occupational-disease hazards often arise. Various government agencies have done much research work to find means to combat such hazards, but it is often forgotten that the research laboratories of private industries also make important contributions to the advancement of knowledge. Only the other day the Anaconda Wire and Cable Company gave a grant of \$30,000 to the New York Medical College for research in industrial medicine, arising out of problems incident to the manufacture of its products. For years industry has supported the Industrial Hygiene Foundation, located in the Mellon Institute in Pittsburgh. Likewise, it has created the recently-endowed Nutrition Foundation. Regardless of how profitable a prod-

uct may be, if it is shown that there is a health hazard, even when its creation has been costly such a product is not placed on the market.

For many years I have been observing industry's attitude toward medical service for its workers, and it has been gratifying to note that there is an ever-increasing friendliness and receptiveness toward better and better medical service. Long before the war brought about the exchange of confidential processes, there were many examples of big industries' willingness to help finance the cost of educational programs to acquaint the small industrialist with what modern medicine has to offer to help him make his plant more efficient.

From my work during the past five years, in visiting industries all over the United States and my discussions with industrialists, I am left with the feeling that real progress is being made in the field of medical protection.

PREVENTIVE MEDICINE IN INDUSTRY*

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Thomas Paine¹ wrote, "War involves in its progress such a train of unforeseen and unsupposed circumstances that no human wisdom can calculate the end." Who could have predicted that the first World War would develop the need for improved industrial medical service, and that the present war would emphasize industrial preventive medicine?

In 1914 the unprepared democracies were forced to undertake a phenomenal industrial program. At that time England and France had little knowledge of the manufacture of synthetic organic chemicals, and therefore had no warning of the importance of proper medical supervision of the making and handling of such materials as T.N.T. All suitable manpower not immediately needed in the Army or Navy was put to work in munitions plants. When men became scarce work hours were increased and women were employed, but bitter experience soon taught a lesson. In France and England many cases of acute poisoning occurred, and loss of time from accidents and minor disability threatened to ruin the whole munitions program.

An official inquiry was made in England, and in 1916 the chief medical officer of the Ministry of Munitions² issued directions to physicians in in-

dustry, including the following very pertinent comments:

"Doctors should realize the distinction between preventive and curative medicine. They are not stationed (in munitions plants) for purposes of carrying out ordinary medical care of sick people. . . . It is of far greater national importance that the incidence of T.N.T. sickness be lessened and, if possible, completely stopped than that this illness when established, together with any other disease that may occur in the factory, should be personally treated. The medical officer should understand the working of the factory from A to Z; he should be familiar with the housing, habits, rates of wages and the traveling facilities of the employees; he should know the relative danger of each . . . process, and be able to offer definite advice as to improvement in sanitation, ventilation, heating, or weather-proofing of the various factories and sheds when, in his opinion, they are defective."

This very clearly defines the duties of the industrial physician and emphasizes that his major job is "prevention."

Since 1916 our country has become the greatest chemical manufacturer and user in the world. This development has made necessary a vital change in and increase of medical practice in industry.

When the United States started manufacture of war goods for the Allies in 1940, it was generally

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association, at Indianapolis, on April 19, 1944.

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¹ Paine, Thomas: *Prospects on the Rubicon*, 1787.

² O'Donovan, W. J.: T.N.T. Poisoning and the Fate of T.N.T. in the Animal Body, I. *T.N.T. Sickness and Toxic Jaundice*, page 28, His Majesty's Stationery Office, London, 1921.

realized that in those branches of industry using chemicals more than usual care must be taken of the health of workers. When we actually entered the war and our own war plants increased in number, the shortage of physicians acquainted with industrial problems led to many programs such as this to instruct and assist physicians who had newly acquired responsibilities for industrial health. Our recognition of the need for increased and improved industrial medical services showed that one of the lessons of the first World War had not been forgotten. However, in at least two major respects we have failed to learn. First, we have not really emphasized that the function of the industrial physician is *prevention*, and not diagnosis and treatment. Second, we have not taken advantage of the knowledge gained between 1914 and 1918 concerning the ill effects of increased working hours.

To illustrate our first point, glance over the programs of symposiums or postgraduate courses on industrial health which have been held in this country since 1940, or textbooks on the subject published in the last three years. Almost every paper or article dealing with medical duties of the industrial physician is concerned with treatment, diagnosis, or rehabilitation; in other words, with conditions which presuppose the failure of a preventive medical program. This indicates a mode of thought which has not yet reached the point attained by the chief medical officer of the British Ministry of Munitions in 1916 who realized "the distinction between preventive and curative medicine." We still confront a problem demanding prevention armed with mental attitudes and clinical procedures designed to diagnose and treat. This is hardly our fault since all of our medical training and practice has been directed toward diagnosis and treatment. We have never learned to think in terms of "prevention," but we must so learn if we are to do our best job during this war and in the years of peace to come.

Successful practice of preventive medicine in industry can not depend on procedures of diagnosis and treatment, that is, on wisdom after the event. It must be founded on a knowledge and a means of detecting physiological changes on the path from good health to clinically diagnosable sickness. These changes are not specific. They may be the same and follow the same course whether they result from exposure to chemicals, disease, malnutrition, drug addiction, or adverse climate. This non-specificity of changes antecedent to clinical sickness appears confusing to those trained in diagnosis and treatment. They fail to recognize the impossibility of correlating non-specific physiological trends with the clear-cut, specific data given by clinical or diagnostic tests. They are frightened by the vagueness of the non-specific, by the multitude of possible causes. They do not realize that to acquire the knowledge necessary for the practice of prevention they must study the day-by-day reactions of man

to his environment, and not the condition of a man who has been injured by and is trying to escape from his environment.

It has been the function of our laboratory during the last seven years to formulate schemes for the prevention of illness among workers in the chemical industry. During that time we have developed procedures which allow us to detect and to follow the trend of physiological changes unaccompanied by specific tissue pathology. Since our procedures are to be used continuously in manufacturing plants, we have concentrated upon methods which give numerical data susceptible to statistical analysis. One method, the measurement and scoring of blood pressure, has been published in detail in *Industrial Medicine*.³ The second, the measurement of the distribution of energy in heart sounds, was published in the April, 1944, issue of *Industrial Medicine*.⁴

The blood-pressure method was developed over some seven years of intensive study of men and animals exposed to a variety of toxic chemicals. It required analysis of thousands of clinical records and had reached beyond the experimental stage in our own plants when first described in public. It depends upon the fact that the absorption into the body of foreign chemicals, or the action of disease or malnutrition in liberating in the tissues abnormal products of metabolism or abnormal amounts of normal products, can result in a general decrease in efficiency of cellular oxidation-reduction reactions. As a result a number of responses are noted, and among these are definite shifts in pulse pressure and diastolic pressure.

At the moment I do not wish to discuss the method in detail, but rather show some results of its application and deductions from these results. However, I wish to point out that in the chemical industry new materials of unknown properties are introduced almost daily. Using physiological procedures of the type we have developed, any physician, however small or great his knowledge of toxicology may be, can quickly estimate the hazards from new materials and control the medical situation in his plant.

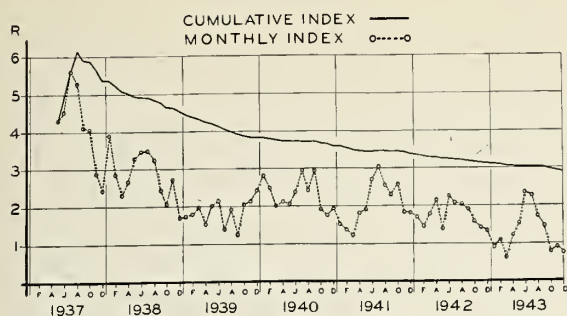
All of our data on blood pressure is summarized statistically, and we use, to follow the trend in plants, an abnormality index or ratio, which is the number of abnormal blood-pressure scores in a group of examinations divided by the maximum number of such abnormals expected in that group by pure chance.

Figure I shows the record of workers in an operation, who have been studied since May, 1937. The circles connected by the broken line show the monthly value of the abnormality index R. The full line shows the cumulative value of R, that is the

³ Foulger, J. H.: Medical Control of Industrial Exposure to Toxic Chemicals, *Indust. Med.*, **12** (No. 4), 214-225, (April) 1943.

⁴ Foulger, J. H.: The Differential Heart Sound Meter, *Indust. Med.*, **13** (No. 4), (April) 1944.

FIGURE I



Seven-year record of blood pressure scores for occupational group in chemical plant.

Broken line and circles: Value of abnormality index by months.

Full line: Cumulative value of abnormality index.

value calculated at the end of each month for *all* examinations since May 1, 1937.

During these seven years, some 866 employees have been studied for various periods of time, and 26,194 blood pressure records have been made. Each involved at least the measurement of sitting blood pressure on each arm, and many examinations included also lying and standing blood pressure measurements used in the Crampton test for blood ptosis.⁵

In a very large population of normal persons, no more than 6 per cent of all examinations should give blood pressure scores of 0.1 or less (which we consider abnormal). Since in practice we can not deal with statistically large populations, we must use the mathematics of chance to calculate how many abnormals are expected in any group of examinations on the basis of the 6 per cent yardstick. Even 26,194 examinations is not a statistically large number. In this number we should expect by chance up to 1,649 abnormal blood pressure scores, that is 6.29 per cent. So long as the value of *R* does not exceed 1.0, the group studied does not, as a whole, contain more abnormal examinations than chance allows, but, of course, individuals in the group may have more than their normal number of abnormal examinations. I will refer to this later.

Throughout the seven years reported in Figure I, the plant has been under close medical supervision, based entirely on some form of study of trends in blood pressure. The value of physical protective measures, such as ventilation, clothing, and personal cleanliness has been assessed by blood pressure measurements. The condition of individuals, their fitness to continue their job, the influence of out-of-plant activities and other factors have been detected and assessed by the study of blood pressure. The index of abnormality based on blood pressure has been used to establish safe concen-

trations of toxic chemicals used in the products of the plant, and as a warning when climatic conditions or production loads are leading to adverse trends. Ordinary clinical laboratory procedures used in diagnosis have very seldom been applied.

When this method of study was commenced in May, 1937, the workers in this plant were in very poor condition, as shown by a value of *R* above 6.0. During the first few months it was necessary in most cases to remove many workers from exposure to chemicals; however, only temporarily. As time went on there were improvements in protection and in the ability of operators to handle materials in a medically-safe fashion. We also conducted nutritional studies during this period.

The result of this intensive physiological control of the plant is shown in the trend of the monthly, and particularly of the cumulative, index. To realize the significance of the fall of the cumulative value of *R* from above 6.0 to 2.9, consider the position of a nation of 100,000,000 people in which during good times the average expected number of unemployed and unemployables should be 6,000,000. Suppose that as a result of financial disaster this had reached a value of 36,000,000, and yet in the course of seven years, in spite of a monthly average often exceeding 6,000,000, it had been possible by rehabilitation and by creating new jobs to reduce the average for the *whole period* to some 17,500,000.

From the point of view of improvement in physiological condition, the plant physician, with never more than one assistant, has performed a major feat in this plant. He could not have done this by spending most of his time in diagnosing or treating obvious poisoning or sickness. He did it because he and the management accepted the significance of physiological warning signs, and so far as production allowed adapted their plant to each situation. The war, which greatly increased production during 1942 and 1943 and which made necessary the employment of women to do the same jobs as the men, did not appreciably affect the steady improvement.

The continued use of the blood-pressure scoring system for a study of workers as well as of experimental animals has given us data upon which to establish a theoretical mathematical formula for development of physiological abnormality during work hours and recovery while away from work. By its use we can learn why, with increasing hours of work and increased difficulties of housing, feeding and care of families while away from work, we face a rising tide of industrial sickness, accidents, and discontent.

The mathematical analysis of blood pressure records shows that for maintenance of physiological normality there must be a balance between the rate of development of abnormality while at work and the rate of recovery while away from work. If development is faster than recovery, we can

⁵ Crampton, C. Ward: The Gravity Resisting Ability of the Circulation; Its Measurement and Significance (Blood Ptosis), *Am. J. Med. Science*, 160:721, 1920.

demonstrate the stages reported in the *Medical Clinics of North America*,⁶ namely:

1. A period of no detectable physiological defect.
2. A period in which functional abnormality has developed at the end of the day's work, but disappears over night.
3. A period in which functional abnormality has developed at the end of a week's work, but disappears during the week-end of rest.
4. A period in which over-night rest is not adequate to restore to normal.
5. A period in which week-end rest is not adequate to restore to normal.

(Our original publication placed Period 3 ahead of Period 2. Development of the mathematical formula shows that this was incorrect.)

Figure II shows a mathematical model of the development of functional abnormality, based upon a 40-hour week. For diagrammatic purposes the development of abnormality is made so rapid that the first stage (the stage of no effect) lasts only a day or two, which, in fact, is quite often the case in industry.

If in a plant conforming to this model we progressively increase working hours, we shall disturb the balance, for we not only increase the time allowed for development of abnormality, but we simultaneously reduce the time allowed for recovery.

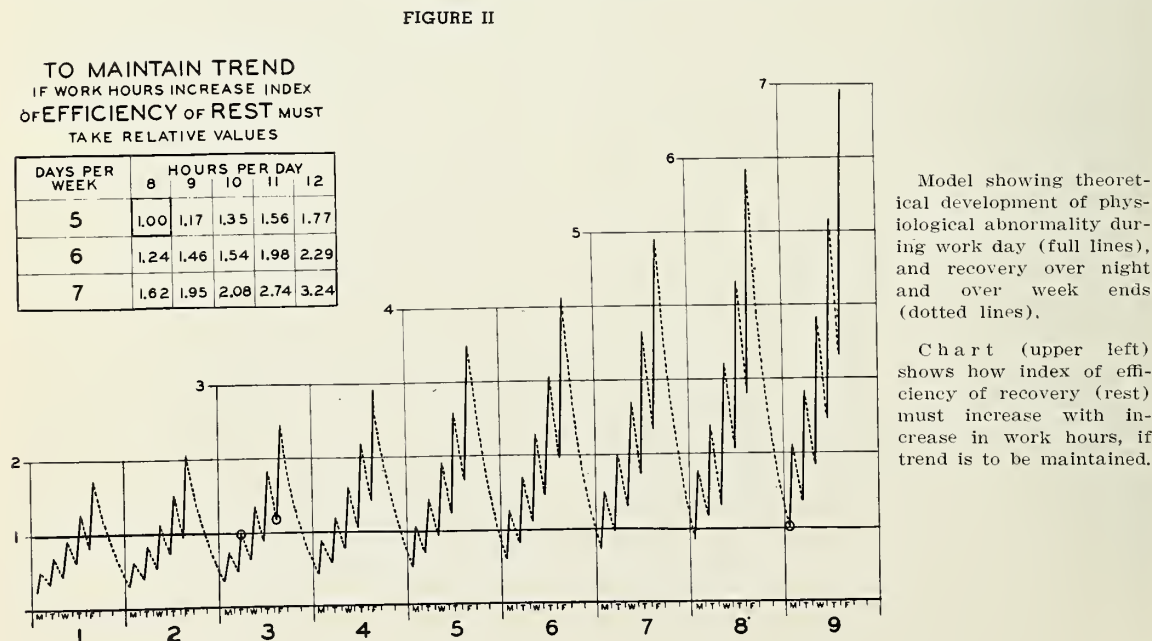
If we wish to increase working hours without speeding up the development of abnormality, we must either greatly improve the industrial environment or increase the efficiency of the recovery

period. The table at the top of the chart in Figure II shows that in order to maintain the trend of the model with an increase in working hours from five days of eight hours to seven days of twelve hours (and such an increase has actually been made in wartime), the index of recovery must increase to 3.24 times its original value if the effect of the industrial environment is not decreased. This index is exponential and therefore needs interpreting. To maintain the trend found during the 40-hour week with an increase in working hours to 84, we must place ourselves in the position of a banker who, having in the past been solvent on an average return of 2.7 per cent on his investment, can now only remain solvent if he receives an average of 9.3 per cent. Even in peacetime it is impossible for a worker to so increase the efficiency of recovery during his non-working hours. It is much less possible under war conditions.

Increase in working hours without comparable improvement in the industrial environment must inevitably lead to rapid physiological deterioration, especially in wartime. If this deterioration is not promptly detected and properly handled, there will inevitably be an increase in industrial sickness.

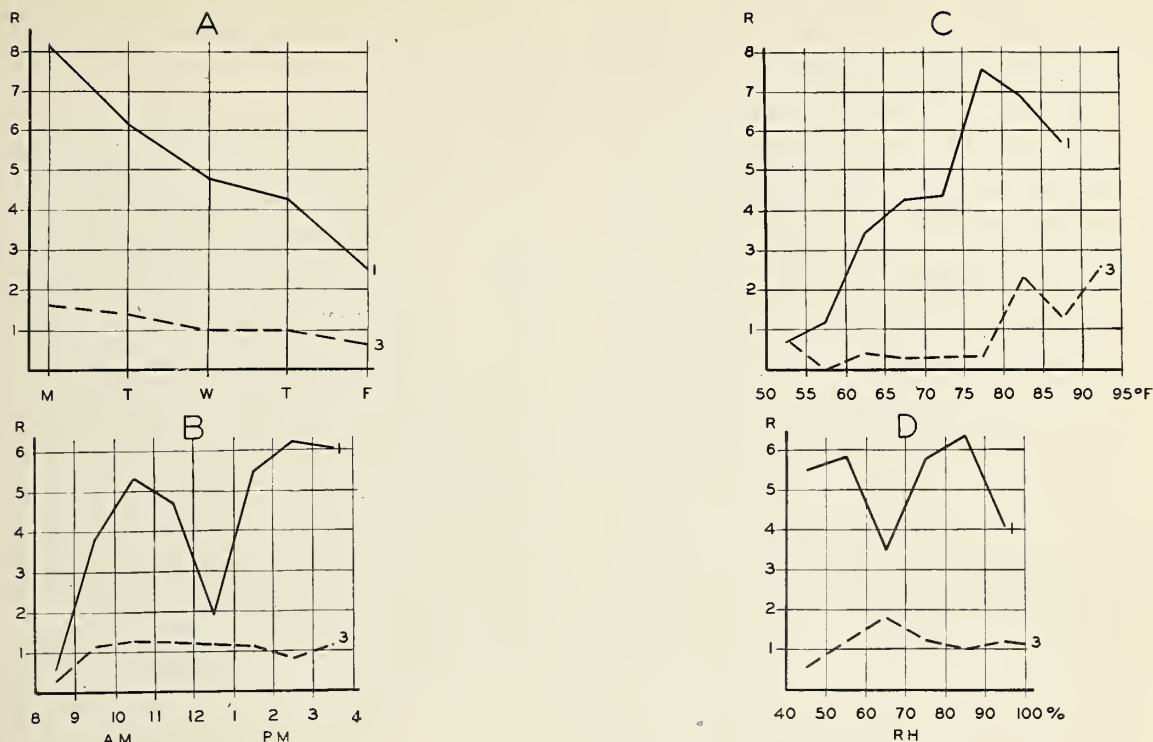
In using the mathematical formula developing such models as shown in Figure II, it is supposed that the non-industrial environment gives adequate opportunity for recovery from the physiological abnormality developed in industry. This may not be the case. There are a number of factors which definitely affect both a man's ability to recover and his susceptibility to the action of the industrial environment. Among these is his state of nutrition.

We have suspected for a long while—and recent facts tend to prove that our assumption is correct



⁶ Foulger, J. H.: Prevention of Ill Health in Industry, *M. Clin. North America*, 1145-1160, July, 1942.

FIGURE III



Abnormality index for abnormal Crampton tests (Crampton index 30 and below) in group shown in Fig. I.

Full line: Period 1: April 1 to September 30, 1938.

Broken line: Period 3: April 1 to September 30, 1939.

During Period 3 each man received 100 mg. ascorbic acid per day.

A—Daily trend of R.

B—Hourly trend.

C—Trend with atmospheric temperature.

D—Trend with relative humidity.

—that a great proportion of our workers are habitually eating food deficient in important food factors, such as vitamin C. If we return to the trend of plant abnormality indices for blood pressure (Fig. I), we shall note that the year 1939 shows the least variability of the monthly index and absence of a definite seasonal trend; that is, an upward swing of the value of R during the hot summer months.

Beginning with April, 1938, we made a study of the Crampton test⁵ on the workers in this plant, and continued it to the end of September, 1939. This test is an index of the ability of the circulation to withstand changes in posture, specifically the change from the lying to the standing position. We used Crampton's table of indices, but made the test harder by considering as abnormal only those tests giving indices of 30 or less, whereas Crampton himself often used 60 as the lower limits of normal. From experience, we should not expect more than 1 per cent of a very large number of examinations on normal people to show a value of 30 or less, and we use this 1 per cent in calculating the trend of events.

The studies of the Crampton test covered three periods:

- (1) April 1 to September 30, 1938.
- (2) October 1, 1938 to March 31, 1939.
- (3) April 1 to September 30, 1939.

At the beginning of Period 2 each man was given 100 mg. ascorbic acid daily. The vitamin was not carelessly distributed. A worker was given the job of distributing the tablets each day and seeing that each man swallowed his supply. (Unfortunately, later in the history of this group, although we continued to give vitamin C daily, this care in distribution was not exercised.)

In Figure III we compare the data of Periods 1 and 3, which are comparable from a climatic standpoint. Figure III—A and B show daily and hourly incidence of abnormal Crampton tests. Figure III—C shows the incidence of abnormal tests with temperature rise and Figure III—D shows the trend with change in relative humidity.

It is seen that during Period I there was a great number of abnormal Crampton values. The value of R calculated on the 1 per cent basis

reached 8.0 at the beginning of the week, and was still between 2.0 and 3.0 on Friday. Moreover, during the hours of the day there was a very definite trend in the value of R, reaching a peak with a value over 5.0 between 10:00 and 11:00 A.M., and another peak with a value over 6.0 from 2:00 to 4:00 P.M. When we gave vitamin C, both the daily and the hourly trend of abnormality of circulation, as shown by the Crampton test, was almost completely eliminated. There were so few Crampton values of 30 or below in this group of men during Period 3 that there was really no trend. You may have noted in Figure I that there was usually a greatly increased value of R during the hot summer months. Figure III—C shows that during Period I, without vitamin C, there was a rapid upward trend of incidence of abnormal Crampton values with increase of temperature, whereas in Period 3 this trend was not at all obvious until temperatures reached above 80° F. There is little relationship between the occurrence of high relative humidity by itself and the occurrence of abnormal Crampton tests.

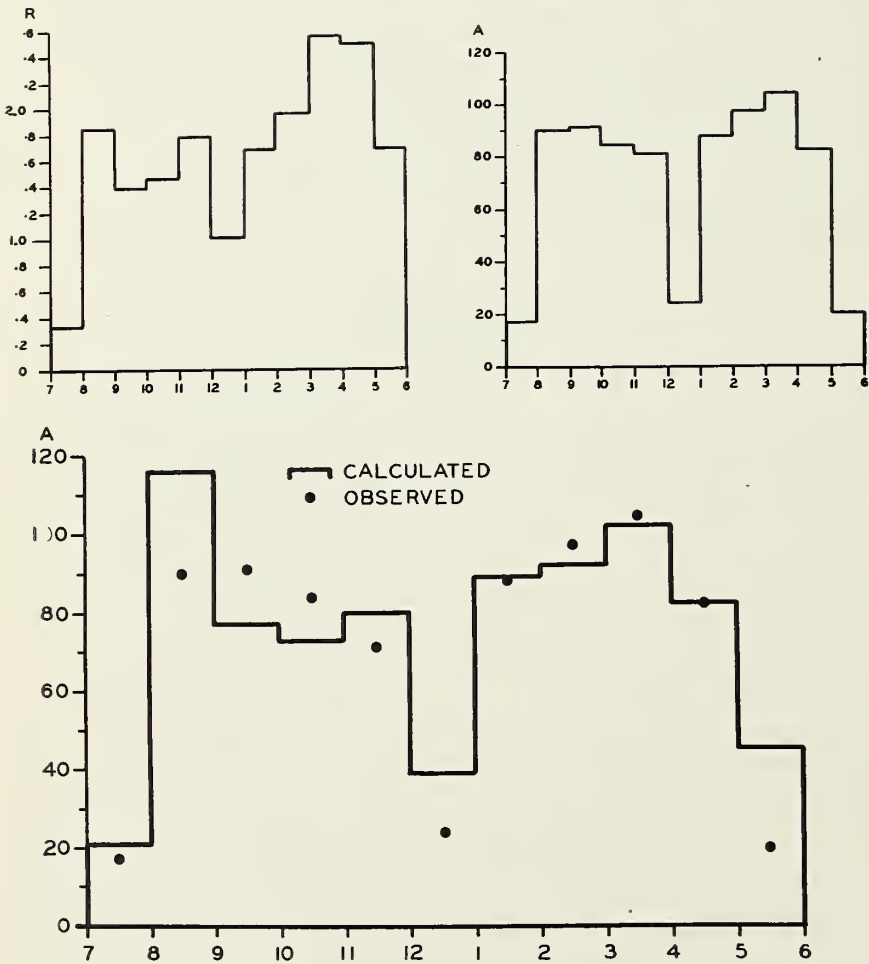
This increased stability of the circulation of workers as measured by the Crampton test, when

they were given vitamin C, is reflected in the more stable value of R for the ordinary blood pressure trend during the period of 1939.

In mentioning knowledge neglected in our war effort, I spoke of the influence of work hours upon accidents. It has generally been accepted that so far as injuries are concerned the physician's sole duty is to diagnose and treat. Yet, as knowledge of the nature and cause of accidents increases there is a growing tendency to ascribe a large proportion to personnel failure rather than to failure of equipment. Thus, the problem of accidents is passing from the realm of the engineer to that of the physician.

In recent months much attention is paid to the so-called "accident-prone" person, and to attempts at identifying him before he is a victim of an accident. Many discriminating industries, notably our transport systems, will not employ an accident-prone man. However, he has often done considerable damage before he is recognized as accident-prone. We can visualize the time when he will be a pariah, unable to obtain employment in any careful industry, and holding jobs in less-demanding occupations only until his particular malady

FIGURE IV



Upper left: Hourly trend of R for group shown in Fig. I during 1942.

Upper right: Hourly trend of accidents in whole plant of which group forms a part.

Bottom: Full line histogram shows calculated hourly trend of injuries on assumption:

(a) Trend of R, being non-specific, applies to whole plant.

(b) Men injured during morning are not again vulnerable during morning.

(c) Eighty per cent of men injured during morning are vulnerable at 1:00 P. M.

(d) Men injured during afternoon are not again vulnerable during afternoon.

Dots: Observed injuries plotted at mid-point of hours.

demonstrates itself. So long as we fail to study the physiological condition of the accident-prone person, or any other person involved in accidents, just so long shall we stigmatize him and fail to help him.

In our studies of work groups by the blood pressure scoring system, we almost invariably find a small proportion of workers in each group contributing most of the abnormal blood pressure records of the group. When we seek the cause it frequently lies in factors outside of industrial work: undue fatigue in outside activity, sickness, family worries, drug habits, or alcoholism. Is it possible that the accident-prone man is also one who is prone to show circulatory abnormality?

Unfortunately, it has been the custom in industry to separate safety and medical department records (except in the case of major accidents) so that there is seldom a correlated safety and medical study. Therefore, to associate the trend of injury with the trend of functional abnormality, certain assumptions are necessary, but by making these assumptions interesting data can be obtained.

In the upper left hand corner of Figure IV, we show the value of R for each hour of the day from 7:00 A.M. to 5:00 P.M. during the year 1942 for the plant record shown in Figure I. The blood-pressure records were obtained only on men working in one type of production, comprising some 150 men out of a total of 850 employed in the whole plant in potentially hazardous jobs. The upper right corner shows the trend of injuries during 1942 over the same hours for the whole plant. Since the blood pressure method is not specific, we assume for the moment that the trend of the blood pressure index during the day for these 466 men can be taken as a picture of the trend for the whole 850 men in the plant. We calculated, in the large diagram of Figure V, the histogram showing the incidence of injuries by hours, using the additional assumptions: (a) that the number of injuries was proportional to the number of abnormal blood pressure scores; (b) that each man injured during the morning was no longer vulnerable during the morning (that is until 12:59); (c) that at 1:00 P.M. 80 per cent of those injured during the morning were again vulnerable, and (d), that after 1:00 P.M., each man injured during the afternoon was no longer vulnerable during the afternoon. The circles show the actual trend of accidents by hours in this plant.

The closeness of the calculated histogram and the observed data is apparent, and justifies for the moment the conclusion that there may be a direct relationship between accident rate and physiological disability, if the bases of our calculations themselves are justified. We believe that they are. Circulatory abnormality certainly tends to make a man less well coordinated. After all, skill is nothing but the dexterous employment of one's knowledge. A man suffering from circula-

tory abnormality, for instance of a type which will not respond properly to changes in posture, cannot be dexterous for long. Further, the fact that we have a record on these injuries shows that each man injured reported for treatment. He would not, therefore, be subject to injury for an indefinite period after the time of his injury. When he returned to work, perhaps he would be more careful. After the lunch period many of those who attended medical treatment during the morning would be back at work. There seems, then, to be a reasonable basis for each of our assumptions. However, to establish these facts on a firm basis, it is necessary in the future that medical and accident records be more closely correlated and that more data be given in the record of accidents, particularly on the number of men actually employed at the time of the accident, and the period of time during which the injured man was away from his job.

If there is a connection between accidents and physiological status, we have in our scheme for preventive medical control a scheme also for reduction of accidents. Two requirements are necessary for an accident: a hazardous situation and a person in such a physiological state that the hazardous situation can operate. If the physiological state is normal, the hazardous situation will not lead to injury. If by protective devices and the manner of work we reduce the hazard of the situation, an abnormal physiological state will not lead to injury. In fact, the physical equipment and the method of working of the men examined, as shown in the chart of Figure I, and the highly dangerous nature of the material which they used led to extremely safe practice. These men, themselves, had so few injuries that I could not use the data on that group alone for correlation with the hourly trend of physiological states. This fact, itself, is in support of our thesis.

It has been shown above that if we decrease working hours without reducing the hazard of the working environment or improving the efficiency of the recovery period out of work, we will inevitably create more sickness. If the physiological status of workers parallels their proneness to injury, then by increasing working hours without controlling the industrial environment in such a manner as to reduce physiological abnormality we will also increase the incidence of accidents.

To summarize: The major function of the industrial physician is prevention, not diagnosis and treatment. To be successful in prevention he must acquire an outlook different from the conventional medical outlook of the diagnostician. He must acquire a fundamental knowledge of physiology and learn procedures to detect physiological changes. Having detected them, he must act upon the warning given, even though no clinical signs of ill health are present. If he does this, the sickness and injury records of his plant will diminish. He will never be able to answer the skeptics

who ask, "How do you know that anything would happen, even if you hadn't gone to all this trouble?" The fact that nothing adverse has hap-

pened to the men's health must be his reward, for in the absence of clinical cases of poisoning he will not be able to write papers on such cases.

FUNGUS ALLERGY AND INDUSTRIAL DERMATITIS*

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It is not at all uncommon to read discussions of industrial dermatitis in which there is mention of the epidermophytids. Many of the authors are not dermatologists, and it is obvious from both the presentation and the discussion that there is a lack of thorough knowledge of the experimental and clinical factors which have been established by more than twenty years of research on this subject.

Skin diseases which are due to fungi and micro-organisms in general can be divided into those which are directly due to these organisms and those special forms which have arisen due to the development of sensitization to the causative organisms and/or their products. The latter have been grouped under the general heading of cutaneous microbids.

The clinical manifestations of the microbids depends on a development of an acquired hypersensitivity to the micro-organisms and their products after the primary infection has existed for some time. The incubation period for the development of this hypersensitivity depends on the micro-organisms to some extent, on individual predisposition as well as many other factors which cause more intimate contact between the living organisms and the living cells of the skin. Here we see a parallelism between the development of hypersensitivity to industrial sensitizers where secondary factors, such as friction, irritants, et cetera, all play a role as contributory factors to the development of hypersensitivity.

In the group of microbids we have the tuberculids, when the causative organism is the tubercle bacillus, trichophytids when a trichophyton fungus is the cause of the primary lesion, epidermophytids when an epidermophyton is the causative organism, and levurids when monilia cause the primary infection. Trichophytid is the general term which has been applied to the microbids associated with fungus infections. The term in the literature has often been shortened to "ids."

While trichophytids are seen with many types of primary fungus infections, as far as industry is concerned the most frequent type of these second-

ary allergic manifestations to the fungi which comes in to question is the presence of an epidermophytid on the hands secondary to epidermophytosis on the feet, which is commonly known as "athletes' foot."

The fungi responsible for dermatophytosis of the feet, as far as the temperate zones are concerned, are the simple species known as *Trichophyton mentagrophytes* (T. gypseum, T. interdigitale, T. pedis, T. niveum, et cetera). This organism is important because it has acquired a high sensitizing power. The trichophyton fungus grows in the non-living layers of the skin and its appendages. It has never been proved capable of living in actual living cells. This is important to bear in mind because inflammatory reactions do not develop unless actual living structures are invaded. When living structures are invaded by the fungi or their products, sensitization develops.

In experimental reproduction of the syndrome of dermatophytosis of the feet in humans, it was shown that with an organism which has a high sensitizing index an allergy can develop as quickly as thirteen days after the primary infection. In some individuals a hypersensitivity to fungi may develop months or even years after the primary fungus infection has taken hold. Trauma, treatment with strong ointments, continuous maceration and other types of local irritation probably hasten the development of this hypersensitivity in many instances.

Demonstration of this hypersensitivity can be shown by means of the trichophytin test. This is an extract of fungi which has been used both for diagnosis and treatment.

The fungi of both the epidermophyton, trichophyton, as well as other groups of fungi, contain a general common sensitizing factor so that a patient infected with the trichophyton or a member of any of the other groups of fungi in whom a hypersensitivity has developed will show a positive reaction to a trichophytin test with an extract made from any of these organisms. It is rare that we meet with a fungus infection where a hypersensitivity has developed to a specific excitant. This accounts for the rare case of trichophytid in whom a trichophytin test is negative. For practical purposes, however, this occasional negative test is so infrequently encountered that it can be dis-

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association, at Indianapolis, on April 20, 1944.

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regarded. Since it is absolutely essential that a hypersensitivity to the fungi and their products must be present before we have trichophytids, and since this sensitivity is demonstrable by means of the trichophytin test, before a diagnosis of trichophytids is made the sensitivity should be demonstrated by means of positive trichophytin reaction.

There are a number of such fungus extracts on the market and they must be properly used and evaluated before the reaction which they produce in hypersensitive individuals can be interpreted intelligently. The commercial extracts are usually prepared in 1-30 dilution, and it is important to make a control injection with the proper dilution of the nutrient media (Sabouraud's bouillon) to avoid false positive reactions. The test is made by the injection of 1/10 of a cc. of the trichophytin intradermally and the reaction is read in forty-eight hours. Delayed reactions sometimes appear as long as a week after the test is made.

We must understand from the beginning that a positive trichophytin reaction means that a patient has once been infected with fungi and does not necessarily mean that an active fungus infection is present at the time the test is read; however, the absence of a positive trichophytin reaction rules out the presence of trichophytid.

Some authors maintain that the incidence of epidermophytosis is so high and so many have already become sensitive that analogous to the incidence of positive tuberculin tests the trichophytin test is so often positive that it is of little practical importance as a means of differential diagnosis. This is a misconception. The test has a high incidence of positivity only in the presence of trichophytids. In a small series of cases studied in 1931, I was able to demonstrate the fallacy of the conception that the trichophytin test was almost 100 per cent positive in the casual patient. In a recent study carried out where many hundreds of patients were tested the observation which we made in 1931 was further substantiated. Other observers, such as Lewis and Hopper, have also concurred in such observations.

The test manifests itself, depending on the degree of hypersensitivity, as an area of redness in those moderately sensitive, as edema, papules and vesicle formation in those more sensitive, and in a few rare instances with a lighting up of the "ids" present or even the appearance of new "ids" in extremely sensitive patients. The local reaction may vary from one centimeter to three or four centimeters in diameter, depending on the degree of sensitivity. Methods of grading the reaction from 1 to 4+ have been described.

The pathogenesis of trichophytids is about as follows: a focus of fungus infection takes place and after an interval of time, which may be several weeks, months or years, hypersensitivity develops. The living fungi or their products find their way into the circulating blood and are disseminated. Actual blood cultures for fungi have been demonstrated. When they come in contact with the sensi-

tized tissue, which in this case happens to be the skin, they give rise to an inflammatory reaction known as the trichophytids. In the case of the living fungi this sometimes gives rise to new foci of infection. This, however, is rare. Once sensitivity has developed new foci of fungus infections which may arise in other parts of the body by contact, or even those already present as on the feet, become more inflammatory due to the local reaction between the fungi and their products and the sensitized living cells.

Criteria have been laid down for a diagnosis of trichophytids which are absolutely diagnostic, but, of course, it is not possible to carry out all of the criteria and in the differential diagnosis of trichophytids from other types of skin eruptions only a few of the criteria need be established. The complete criteria are as follows:

1. The causative organism must be demonstrated in what is recognized by every one as a classical manifestation of the disease.
2. While it is not absolutely essential, the organism which is cultured from the primary lesion should be pathogenic.
3. A positive reaction analogous to a tuberculin or a trichophytin reaction must be present.
4. What is considered to be microbid should be seen as frequent accompaniment of the primary lesion.
5. Positive blood cultures for the same organism isolated from the primary lesion must be obtained, since it is admitted that most of the microbids are hematogenous eruptions. This is necessary because there is no reliable method of demonstrating the presence of circulating toxins.
6. The microbids must develop subsequent to the primary infection.
7. The microbids must usually be sterile.
8. A support for the conception of a skin eruption as an "id" lies in certain clinical characteristics:
 - a. Appearance of the "ids" in showers.
 - b. Tendency to symmetry in distribution because of hematogenous origin.
 - c. Tendency to spontaneous involution after healing of the primary focus.
 - d. Focal reactions after injection of sufficient amounts of microbidin (trichophytin).

Varieties of trichophytids

Different fungi can elicit the same clinical picture and totally different clinical manifestations can be found associated with the same fungus. However, in a majority of instances various types of trichophytids have been found commonly associated with certain of the primary fungus infections. Thus, the inflammatory fungus diseases known as Celsus' kerion, which is found on the scalp is commonly accompanied by a generalized eruption on the trunk, known as lichen trichophyticus, while epidermophytosis of the feet is usually accompanied with a vesicular eruption of the hands. In order to understand the types of tri-

chophytids which may develop, we must bear in mind that the localization of the embolized fungi or the greatest concentration of the products of the fungi and the site of the greatest skin sensitivity play an important role in the morphology of the resulting trichophytid. As the organisms and/or their products become localized in the small blood vessels of the subcutis, a subcutaneous trichophytid develops (erythema nodosum). As they become localized in the vessels of the hair follicle lichenoid forms result. Since the epidermis is especially sensitized, vesicular eruptions or even eczematoid eruptions may appear and a scarlatiniform "ids" have been described where the organism was flooded with toxin.

Table I includes the types of trichophytids which have been described. As I have mentioned previously, the trichophytids associated with fungus infection of the feet are overwhelmingly the vesicular eruptions on the hands. While the types enumerated in Table I are possible, their occurrence

is such a rarity that the burden of proof for their being trichophytids rests on the one making the diagnosis.

From the viewpoint of the industrial physician, the differential diagnosis of trichophytids from other industrial dermatoses narrows itself down to the vesicular and eczematoid eruptions on the hands, which are the most frequent trichophytids associated with fungus infections of the feet. I wish to make the point particularly clear that trichophytids of the hands are infrequently met with in industry, just as they are not common in the general population. For this reason, when an eruption of the hands occurs in an industrial worker, a contact dermatitis rather than a trichophytid should be thought of first.

The following criteria are practical and should be carried out in the differential diagnosis of contact dermatitis and "ids":

TABLE I
TYPES OF TRICHOPHYTIDS (MODIFIED AFTER BLOCH)

- I. Epidermal trichophytids (epidermis mainly involved):
 1. Eczematoid (dyshydrotic).
 2. Lichenoid.
 3. Parakeratotic.
 4. Psoriasiform.
 - II. Cutaneous trichophytids (papillary body mostly involved):
 1. Diffuse forms:
 - a. Scarlatiniform exanthemata and enanthemata.
 - b. Erythroderma.
 2. Circumscribed and disseminated forms:
 - a. Follicular localizations usually lichenoid.
 - b. Not exclusively follicular.
 - (1) Macular, papular, and even exudative eruptions.
 - c. Erysipeloid.
 - III. Subcutaneous trichophytids (nodules found in the hypoderm of the type of erythema nodosum):
 1. Acute resolving form.
 2. Destructive chronic form.
 - IV. Vascular trichophytids:
 1. Migrating phlebitis (venous).
 2. Urticaria (capillary).
1. The presence of an active fungus infection should be established.
 2. The trichophytin test must be positive before a diagnosis of "ids" is made.
 3. The eruption on the hands suspected of being an "id" should not improve after a suitable removal of contact with known or suspected industrial irritants.
 4. No improvement should occur when fungus infection on the feet is treated if we are not dealing with "ids."
 5. The clinical appearance of the eruption must be borne in mind.
 - a. Trichophytids are more frequently seen on the palms and on the sides of the fingers, flexor portion.
 - b. Contact dermatitis is most often seen on the dorsum of the hands.
 - c. Trichophytids are usually symmetrical.
 6. In spite of the clinical appearance and a positive trichophytin test, patch tests with suspected chemical irritants must be made. If the patch test is positive and the trichophytin test is positive, there may be a combination of an "id" and a contact dermatitis.

ABSTRACT: RARE CASE OF SILICOSIS CAUSED BY WHEAT DUST IS REPORTED

A case of silicosis caused by wheat dust is reported by Thomas F. Heatley, M.D.; Dalton Kahn, M.D., and C. R. Rex, M.D., Toledo, Ohio, in *The Journal of the American Medical Association* for April 1. Silicosis is a disease of the lungs caused by fine particles of silica. It is generally found among workers in mines and tunnels, stone cutters, especially granite workers, and sand blasters. Wheat dust has been rarely reported as a cause of the disease.

The three Toledo physicians say that a man, aged 55, came to them March 4, 1941, with a complaint of severe difficulty in breathing on exertion, a dry cough and pain in the chest. Up until 1929, when he took a job with a

railroad unloading cars of wheat and storing the wheat in elevators, he had never lost time from illness or sought medical advice. Part of his work was in a tunnel where a traveling belt carried the wheat to an elevator and dumped it there. In 1937 he was obliged to quit because of progressive shortness of breath. He had no history of pneumonia or tuberculosis nor was there any demonstrable evidence of either disease when the three physicians examined him. It was found that he had advanced silicosis. These findings were significant in view of the fact that it is estimated that about 75 per cent of those who develop silicosis die of tuberculosis. Examination of the dust in the tunnel revealed that the silica content was 9.96 per cent and in that in the car 19.96 per cent.

POST-WAR INDUSTRIAL HEALTH PROBLEMS*

R. L. SENSENICH, M.D.

SOUTH BEND

No one living during the war now in progress will remain untouched by the effects of this world upheaval. That portion of society concerned with the production of goods, and classified as industry, will of necessity undergo many readjustments. New products and redesign of older products, and new processes and methods in manufacture, create new exposures and produce unpredictable effects upon workers.

Social evolution will require more consideration of the physical health and well-being of those employed in industry. Greater participation by labor in the responsibilities of management in industry will direct attention to the importance, in productive accomplishment and cooperative effort, of the mental and personality levels among those employed. Education in health is needed. About 90 per cent of sickness absenteeism is due to ordinary illness and off-job injuries. Recent union-sponsored medical service plans have stressed: (1) physical examination of workers; (2) investigation of industrial environment; (3) health education, and (4) rehabilitation.

Society could not financially afford to employ only the physically and mentally perfect and support the less qualified in inactivity, nor could it long endure the effects of mental deterioration and the deformity of personality that would follow among those of the group thus excluded.

Industry, therefore, must bear its full responsibility along with other divisions of society in utilizing those capable of only limited service. It is even more important that industry shall assist in the salvage of the priceless social potentialities of those whom the war took from industry and who will return to it with some impairment. No rehabilitation is complete until the individual is returned to a useful and self-respecting position in society, within the range of his capabilities and inclination.

Unnecessary institutional care or long convalescent support, beyond the time necessary for a reasonable degree of physical restoration, and out of proportion to the impairment, leads to unhappiness and deterioration and not to the desired rehabilitation.

Industry must, therefore, participate in the rehabilitation of those who have made great personal sacrifices for it. Managers of industry now seek, and will need in increasing numbers, medical men of good judgment to evaluate the physical possibilities of those employees and direct their

placement in industry. And employees will need advice and treatment by medical men.

In considering those impairments resulting from service with the armed forces, it has been stated that those whose condition will not permit return to duty will be discharged when sufficiently recovered to make release from hospital care possible. It then becomes the responsibility of the Veterans Bureau to undertake vocational rehabilitation to which the discharged soldier is eligible if the condition is service connected. If the impairment is not service connected, the Federal Security Agency may provide such rehabilitation.

There are certain restrictions governing the eligibility for this vocational rehabilitation and limits as to the time it may be continued. The following, taken from a communication covering this point, is self-explanatory:

"It is anticipated that the vocational-training program will consist of institutional training or 'training on the job,' or such combination of both, predicated upon the individual veteran's educational level, past vocational experience, and present desires, as will restore his employability lost by reason of a service-incurred disability.

"It is the present intention of the Veterans Administration to utilize existing accredited and recognized training facilities in making such training arrangements as may be necessary in the individual case." No doubt the Vocational Rehabilitation Division of the Federal Security Agency will also utilize similar facilities and methods of combining "on the job training" with institutional training.

Civilian Hospitals also may be utilized for care of some of those released from military service, especially the Auxiliary Services—for whom there may be insufficient facilities. They are entitled to provision of necessary assistance in rehabilitation.

Rehabilitation will, of course, not be limited to those released from Government service, but will be extended also to those whose impairment arose from service in industry. Rehabilitation and placement of the physically handicapped requires: (1) a study of the health conditions in the industry in the particular plant, and (2) a careful evaluation of the physical capacity of the individual and the possible effects of various factors arising from the physical effort in that particular job, as well as those resulting from any exposures incident to that particular operation in the factory. For example:

- (a) Hazardous machinery.
- (b) Heavy lifting.
- (c) Employment at heights and possibility of falling.

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association on April 19, 1944.

(d) Dust, fumes, and skin irritants.

(e) Extensive walking or standing.

In general, the effects of fatigue, noise, monotonous repetition of the same operation, the effects of exposure to heat, gases and oil ordinarily considered not harmful, and similar conditions must be considered.

Nutrition is of importance to all employees. On the job, feedings may be required and special feeding, as in diabetes and chronic gastro-intestinal conditions, may be undertaken.

A medical organization with adequate facilities and necessary nursing personnel must be created in plants not so equipped. Physicians and nursing personnel may be responsible for health education.

Cooperation must be maintained between State Departments of Industrial Health and Industrial Physicians and Surgeons. A much better understanding between management, labor, insurance, law and medicine is being developed through the efforts of the Council on Industrial Health of the American Medical Association.

Why refer to these health measures as post-war? Because a limited number of physicians trained in industrial health, war plants in remote areas without complete facilities; new products and wartime pressure of production have made it impossible to accomplish the development of industrial medical services at desirable standards. This development will continue at an accelerated pace in the post-war period.

I have discussed mechanisms. What about the requirements as to medical qualifications? Although most illnesses of those employed present no pathology that is new and different from that accompanying the same illness in those not employed in industry, there will, however, be some new problems in the field of medicine incident to the end results of some diseases acquired in military service in foreign lands. Also, industrial activities develop symptoms and pathology peculiar to that industry. Psychosomatic factors in the development of symptoms are frequently in evidence and are of more importance in group employment in industrial plants than among the civilian population. Recognition of this is important in rehabilitation. Much of this will fall within the average experience of the

physician in general practice, and he will need only a better understanding of the new causes and motivations.

Some formal training is necessary to the best efficiency of the industrial physician. However, good general medical and surgical training and experience will serve as a basis upon which to prepare for this newer field in medicine. The specialty of industrial medicine offers much, but it also requires much. The number of medical men now active in the field of industrial health, the increase in the quantity and quality of literature, the number of clinics and conferences, as well as formal courses in these subjects, provide new stimuli to interest.

What about post-war demobilization of industry and resumption of peace-time activities? Those best qualified to judge point to the accumulated demand for peace-time products as an economic cushion for this period. Reconversion will not all be accomplished at one time. The smaller plants in which a large volume of our industry is carried on will require a minimum of reconversion, but will require much in the way of industrial health organization.

Release of medical officers from military service will be by a process of selective demobilization, and all the physicians in military service will not be returned to civilian life in one group. Many will seek refresher courses or more prolonged periods of medical training in new specialties. It would seem that attractive opportunities are present in a most interesting field of medicine.

It must be emphasized strongly that rehabilitation is primarily a medical function, and the medical profession should make every effort to insure proper participation in all rehabilitation plans.

The medical man in industry should be free from all plant personnel and employment problems or arguments—a scientific man and friend, having the confidence of both labor and management.

Labor and management are cooperating fully with the Council on Industrial Health of the American Medical Association in planning for an Industrial Medical Service of the highest standard through mutual understanding of problems and voluntary efforts to meet them.

ABSTRACT: ERGOTAMINE TARTRATE MAY BE OF VALUE IN TREATMENT OF "BATTLE REACTIONS"

On the basis of a limited experience it is felt that ergotamine tartrate is of some value in treating the reactions to battle, Robert G. Heath, M.D., Passed Assistant Surgeon (R), and Florence Powdermaker, M.D., Surgeon (R), U. S. Public Health Service, Gladstone, N. J., report in *The Journal of the American Medical Association* for May 13. Ergotamine tartrate is a substance related to ergot.

The term "battle reaction" is used by the two physicians to designate the reactions of those whose adjustment had been satisfactory until subjected to a battle experience which proved overwhelming. The reaction,

in contrast to a true neurosis, is regarded primarily as a physical disturbance, the result of inordinate fear causing pronounced sympathetic nervous system over-activity. The two investigators say a cycle is established as a result of this autonomic imbalance. Physical changes primarily and, to a lesser degree, superficial mental mechanisms increase the patient's sensitivity to fear, causing the reaction to intensify and persist. Ergotamine tartrate, given by mouth for 10 days, tends to counteract the increased amount of epinephrine produced by fear. It has been given to 20 merchant seamen. The investigators hope that other physicians working with similar types of patients will continue the experiments.

THE JOURNAL OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

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JUNE, 1944

Editorials

Although this issue is devoted to Industrial Health, the front cover is dedicated to the Fifth War Loan campaign, in answer to our country's need.

THE FIFTH WAR LOAN

The Fifth War Loan campaign will open as of June twelfth, continuing until July sixth, and the amount asked to be raised is the sizeable sum of *sixteen billion dollars*. Six billion dollars of this amount is to be sought from individual investors, which means you and me, and the banks are to take over the other ten billion.

It is officially stated that some fifty-five million individuals own at least one War Bond, which means that more than one-half of our population does not have a *personal* interest in such matters.

Generally speaking, physicians have been consistent buyers of these securities, although by no means in such measure as they should. Millions of Americans are "tithing" these days — that is, they invest exactly one-tenth of their cash income

in War Bonds. If every physician did this the sale would be materially increased.

Now, what about War Bonds — how do they rank as an investment? In our opinion they are "tops" — just that. They pay a reasonable rate of interest, and for safety they cannot be excelled by any other form of investment. Nothing can give us a deeper sense of security than to pick up a sheaf of these bonds, look them over and be able to say, "These are mine — they belong to me; thus I am helping to win the war and at the same time conserving my own resources."

We have reached the crucial stage of the war. The invasion is at hand, both in the Atlantic and the Pacific; we all have near and dear ones in the services ready to give their*all when the time comes. Those of us remaining at home are gainfully employed, doing the things that must be done to keep the war going, but there is one thing more we can do — buy War Bonds. A billion dollars must be a lot of money, then multiply that by sixteen and the sum becomes huge. A few years ago we would have said it would be impossible to raise so much money as has been invested in War Bonds, yet the total amounts to more than eighty-seven billion dollars.

Let's cut a few more corners, let's cut out a few more luxuries; let's get down to brass tacks; let's buy bonds to the limit, and more. Eighteen dollars and seventy-five cents a week, invested in these bits of paper, will amount to \$1,300 at the end of a year, and by adding a little more from time to time, when collections are especially good, we find ourselves possessed of a sizeable sum of money.

Then, too, after having made the investment, let's hold on to these valuable bits of paper. Nothing is more disconcerting to us than to stand in line at the bank teller's window and see "Government checks" being passed in for redemption, each of these checks representing the sale of a bond that was bought not long before. There are those that *regularly* turn in these bonds just as soon as the redemption period arrives, then buy another — too often claiming credit for being a regular buyer.

Buy 'em and hold 'em! should be the slogan of every true American.

THE INDUSTRIAL HEALTH CONFERENCE

Indiana scores again! When we set out to do something, it is done in a big way. A year ago we held our first Industrial Health Conference and it was such a success that it was decided to make it an annual part of our program; so it is with much satisfaction that we report the second conference as being very much worth while. The attendance was not up to expectations, perhaps, but the reason for this is patent—too many physicians found themselves so occupied with their daily cares that they simply could not find time to get away in such a

busy season. This also is true of many plant officials who otherwise would have been present.

However, the program was carried out in every detail, several of the speakers finding themselves involved in several discussions as the program went along, this being much to their liking. We heard one nationally-known authority remark, "The size of an audience never bothers me; I would much rather talk to a small group, each of whom has a genuine interest in my subject," and that is just what we had on this occasion, a not-too-large group of men, all interested in what was going on.

We question whether a similar program ever brought together so many bona fide authorities on the various subjects discussed. We had men from the Army and the Navy, men from big and little industries, and men who are devoting all their time to research along industrial health lines; such a program could not fail to be of the top-notch variety, which is just what it was.

The whole field of Industrial Medicine was covered, and covered well. Not only were fractures discussed; not only were certain occupational diseases threshed out — every subject having to do with modern industry came in for proper consideration. The Public Relations aspect, under many other titles, had its day and was very well handled. Personnel, that bugaboo of former days in our industrial areas, was very well covered, as were many other allied topics.

THE JOURNAL is more than pleased to dedicate this number to Industrial Medicine, a subject that in the last few years has come to be of general interest and one with which practically every member of our association comes into daily contact. It is our prediction that Industrial Medicine will, as the years come and go, become more and more important, and that greater recognition will be given it.

We will not specifically mention the various papers presented, but there was one subject of great interest to every physician who sees industrial cases — a subject that might have been entitled "loss evaluation"; just how much loss has been sustained through injury is a mighty important question, and one at which physicians too often are at loggerheads. Most of the papers presented will appear in THE JOURNAL; not all can be used in the current number, of course, but they will appear later.

The dinner meeting held at the Indianapolis Athletic Club was one of the pleasing features of the session. The dinner speaker was Dr. Victor Heiser, of New York City. Doctor Heiser is known, officially, as the Medical Consultant to the National Association of Manufacturers, but medically he is known as a physician of wide experience, having traveled well over the world. He is the author of many books, probably his best known work being "The American Doctor's Odyssey."

Doctor Heiser is a fascinating speaker. He takes his medical audience with him in his travels about

the world. He gives an intimate picture of some of his work in the matter of re-establishing the health of the people of a nation, and his comment on beri-beri was most interesting.

Then, of course, there was a humorous touch to the dinner program; a lanky chap was introduced as a national character presently well known to the medical profession. The speaker proved to be an Indianapolis attorney who has developed the pleasing custom of taking a homely subject and making a good speech about it, injecting much humor therein. On this occasion he chose to talk about "The Piano."

The second-day session, like the first, teemed with topics of everyday importance, and when the meeting closed it was the unanimous opinion that Indiana again had done something in a big way.

ANOTHER BUBBLE BURST

Just a short time ago, when the magic of sulfa therapy was flowering into full bloom, we were promised freedom from the scourge of gonorrhea. Brothers of the literary art splashed the glad-some tidings all over the printed landscape. At last we had the magic pill which would quickly and economically free the populace of this disease. Even the Surgeon General of the United States Public Health Service was quoted as asserting that ninety out of one hundred patients were cured with one five-day course of treatment, and that six of the remaining ten would be cured by a second course.

Some of us who were treating this malady were unable to get our results to conform to these figures. Shadows of doubt were first cast over this rosy scene when cultures were substituted for spreads to demonstrate the effectiveness of the magic treatment. Percentages of cure fell sharply.

Now, Dr. P. S. Pelouse has had the temerity to challenge the efficacy of sulfa therapy, and states that the percentages of cure are much lower, probably 60 to 65 per cent. He advocates a return to the use of local treatment as an adjunct to sulfa drugs, for those who in their enthusiasm had abandoned it.

At the present time penicillin is being played up as another magic preparation to eliminate gonorrhea. Would it not be wiser to have ample proof before we go overboard again, only to find that there is insufficient water in the pool? It might save a few headaches. Also, it might not be such a bad idea to heed Pelouse's admonition to really learn the social, physiological, and medical ramifications of the disease. Gonorrhea has all these aspects, and memory does not call to mind an instance in which success has been attained by the application of the magic arts to a single phase of any disease.

A PUBLIC HEALTH SCHOOL

Numerous factors are responsible for the present great interest in matters pertaining to public health, this subject commanding more attention than at any time in former years. The war situation is, of course, responsible for much of this, and the publication of the percentage of American youth who have failed to meet Service health standards is to be credited with much of this interest.

Then, too, we must consider the wealth of health information disseminated as a result of the public interest in the Wagner-Murray-Dingell Bill. Practically every newspaper in the land has carried numerous stories about this proposed bit of legislation; medical groups have broadcast their opinions, and these opinions have met with a hearty reception in most instances.

It is a fact that the American people are now health-minded; they want to know more and more as to what can be done to prevent this and that illness; they want to know why we have epidemics and what can be done to control and prevent them. It is to the medical profession they must look for these answers, and the medical profession therefore must ready itself for the task.

We all recognize the importance of health departments, not only in our cities but in the rural communities as well, and we also know that good health officers do not "just happen"—they are created only by proper training, plus experience. We in Indiana long have talked about a full-time health officer measure, seeking to make it possible for every city and county within the state to have a full-time, well-trained man in that job. We have seen this accomplished in some sections, but in too many localities our health activities are too limited.

As we have said, proper training is the essential thing; that is why our Public Health Schools have met with so much success. Medical men go there because they want to learn how to become *real* health officers. The men in the armed services have learned a lot about these things, and this information has filtered back into our medical schools to the degree that hundreds of our medical students have in mind a "Public Health" career. We personally know of several such students, and their enthusiasm is unbounded. They seem to sense that they will be preparing for a worthwhile job—a life-time job.

One of the present difficulties is that there are too few such recognized schools, about a half dozen in the entire nation. We could use more such schools, and there will be more of them in time.

Thus, we approach the question we have in mind—Why not a Public Health School in Indiana? We have thought a lot about it; we have talked to many men about it, and of late the idea seems to be most enthusiastically received in many circles. Here in Indiana the matter has the support of the State Board of Health, Indiana Uni-

versity, and the University School of Medicine. The Director of Health, Doctor Rice, President Wells of Indiana University, and Dean Gatch of the medical school each have professed a marked interest in the project. Surgeon General Parran, of the United States Public Health Service, has indicated that the project would receive his every support and even has intimated that a sizeable grant might be had for the undertaking.

Indiana is unusually well equipped for such a plan. In our medical center at Indianapolis we have a "natural" in the way of physical equipment, what with the medical school itself, the various hospitals, the teaching staff—second to none in the country—plus a most capable State Board of Health staff. We are centrally located, and such a school here would cater to a large medical population.

Few places about the country have an equal setup, and few places have comparable clinical facilities. In addition, we have an industrial field possessed by few other communities.

It all sums up to this: more such schools are needed, more will be brought into being, and some of them will have to build from the ground up. Here in Indiana we have everything at hand and, beyond a lot of planning and a comparatively minor investment, such a school could easily be established. A lot of propaganda will not be necessary; we are sure that the Indiana press will at once endorse such a program and that Indiana folk, once they are properly advised as to what it is all about, will give their unqualified endorsement.

Much more might be said on the subject, and more will be said; the present statement is merely preliminary and will be followed later on by comments from those who are in a position to know what it is all about. We feel that Indiana here has an opportunity to fill a real need, and at the same time add to her educational glory. We have an enviable record in matters educational, and the adding of another phase will be well worth our while.

EVERYDAY PSYCHIATRY

Selective Service examinations and battle-front reports are focusing attention on psychoneurotic and psychosomatic disorders. Newspapers, magazines and the radio are all bringing these conditions to the attention of the public.

It has been much too common for physicians to concern themselves only with the physical manifestations of disease and to neglect or completely ignore psychic illness. Emotional disorders include not only the psychoneuroses but also the inadequacies of the psychopathic and the delinquent adolescent, the behavior problems of childhood, the schizoid personality, and the pre-psychotic states. These emotional defects are all too free-

quently an underlying causative factor of the patient's illness. They "sound off" by way of an almost endless chain of complaints of physical symptoms which exhibit physical pathologic change, yet are caused primarily or greatly exaggerated by emotional discord. Duodenal ulcer is a classic example. Many believe that duodenal ulcer is always preceded by a psychic disturbance, and that permanent elimination depends entirely upon the correction of the psychic disorder. Few, indeed, are the diseases in which psychic derangement may not play a more or less contributory role, yet many physicians state flatly that they know nothing of psychiatry.

Back in the days when the Sage of Hammond was disporting himself in sylvan innocence along the banks of the Wildcat and my shirttail fluttered frequently in the breeze along the edges of Eel River, the Doctor of that day enjoyed great repute among his patients because of his profound knowledge of the patient's own particular and peculiar constitution. "Doc" did not have much in the way of equipment. By present standards his methods could not, by the wildest stretch of a delirious imagination, be termed "scientific." Ma took sister Mary, aged nineteen, to the doctor's office because "Sis" was pale and losing weight, and wasn't enjoying her vittles because of a "kinda puny stomach."

"Doc" could not order a GI series or check up on her vitamin intake; neither did he do a blood count, an analysis of the stomach contents or check up on the hemoglobin. The old ignoramus was blissfully unaware that there was a slight filling defect of her gall bladder, a hyperacidity of the stomach contents, a low red count, or that the hemoglobin was down to 70 per cent.

He decided that she was not feverish, after placing his hand on her forehead. He did not own a stethoscope, so he placed his ear on her chest and listened to her heart and lungs, but dispensed with the idea of having her disrobe, out of deference, to her modesty. He had her lie down on a couch while he palpated her abdomen, maintaining a facial demeanor denoting ineffable wisdom. He took a look at her tongue, gleaned the knowledge disclosed therefrom by the faulty illumination of a smoky coal-oil lamp.

"Doc" then went into a back room and emerged with a bottle of "bitters," to stimulate Mary's appetite, and collected four bits from Ma. Later on he caught Pa and convinced him that the neighbor boy that Mary was mooning about wasn't bad son-in-law material, and that Pa and Ma were not using very good judgment in opposing their marriage. Mary is a grandmother now, and worry over a favorite grandson in the South Pacific doesn't do her digestion any good, but, believe it or not, she still has her gall bladder and appendix. She never did need those bitters that old "Doc" gave her—all that she needed was for

Pa and Ma to allow her to live her life with a mate of her own choosing.

What is the reason for this drivel? Well, two things. Of late there has been some talk that the pathological findings are not backing up the procedure of some surgeons. This rumor has come from different men in different communities. This outburst is occasioned by the fact that shortly after hearing the rumor in connection with a certain surgeon, the writer was compelled to listen to an "organ recital" rendered by one of the surgeon's lady patients. The lady was positively symphonic in extolling his virtues as a physician. She had gleaned her paean of praise from personal experience while undergoing five surgical assaults on her torso within the past six years. She proudly proclaimed that she is being groomed for a sixth foray.

Now this wonderful doctor has the reputation of being a good surgeon. It would seem impossible that he would miss pathology necessitating surgical intervention. In the patient's words, her next operation is to be of an exploratory nature. It strongly occurs to us that exploration of the patient's psyche might yield better results than any more roamin' in her abdomen. In other words, somebody needs a psychiatrist: the patient—surely, the surgeon—perhaps, me—probably. Say, why not all three? If he knows his business I'll bet he finds something!

ECONOMIC DESTRUCTION OF THE MEDICAL PROFESSION*

"Unless the medical profession becomes better organized and pays some attention to the economic phase of its work it will not be long before the practice of medicine will be lower than the level of a trade. While on every hand we find remuneration and conditions of life improving for people following other vocations, in the medical profession there is no such advance. In fact, there is a strong tendency to place the practice of medicine under such regulations by law that there will be little or no incentive to put in the time, effort, and expense in preparation with so little chance of reward except that which comes from service to mankind, and we cannot all give service without money and without price if we are to continue to feed babies at home and buy gasoline for the Ford.

"The worst feature of the situation is that the

* The above editorial appeared in the June, 1919, issue of THE JOURNAL and is reprinted in full herewith. We do recall several conversations with Doctor Bulson concerning the editorial and were agreed that the gradually-increasing "State Medicine" programs that were being adopted would in the end result in much mischief. We consider this editorial, written twenty-five years ago, as quite prophetic inasmuch as many of the evils prophesied already have come to pass.

medical man himself sits back and complacently watches the developments around him which threaten to destroy any equitable standing he may now possess, with but few words of protest and less effort to prevent the oncoming catastrophe. State medicine has been adopted by some of the states, and undoubtedly will be adopted by more of the states within the near future. That state medicine will be developed and expanded there is not the slightest question of a doubt, and while we have nothing to fear from state medicine as it is applied to those deserving of either gratuitous or inexpensive medical care, yet the agitation on the part of some reformers for a law compelling all physicians and surgeons to make charges that shall be on a par with the charges that will be allowed through the restrictions that are thrown about state medicine seems very much like legislation that will put a learned profession out of business through the stifling of incentive.

"The peculiar phase of the situation is that organized labor, haughty, arrogant and autocratic, and even unjust in its demands for higher compensation for itself, is in a measure responsible for some of the agitation and efforts to limit the compensation to be derived from the practice of medicine. Evidently the agitators lose sight of the fact that the average doctor earns less per year than the average skilled mechanic, and yet the doctor, from the time he leaves the grade schools, puts in at least ten and more often twelve years of study, at large expense and with absolutely no income during that time, before he is permitted to engage in professional work. The skilled mechanic, on the other hand, may start to learn his trade as soon as he leaves the grade schools, but is receiving compensation during the time that he is learning his trade, and at the end of his apprenticeship, that varies from six months to two years, he graduates into a full-fledged skilled mechanic with the rewards in the way of remuneration that go with such a position.

"The old saying, 'The Lord helps those who help themselves,' seems to be true in the case of those who would prosper and save themselves from being trampled to death in the mad rush for comfortable subsistence, and the medical profession for self-preservation must unite in some effort to protect itself from economic destruction."

RED-LETTER DAYS

A. M. A. Meeting—June 12-16

Annual Conference of the Indiana State
Medical Association—October 3, 4 and 5

Editorial Notes

The editorial on the use of sulfa drugs in the treatment of gonorrhea, published in this issue of *THE JOURNAL*, is written by a man who has had a world of experience in the treatment and management of venereal diseases, hence, his expressed opinion is backed by knowledge. We would like to hear from other physicians concerning this subject.

We were pleased to have Dr. Verne Harvey back with us for a few days during the Industrial Health Conference. He was on the program and his paper is among those published in *THE JOURNAL*. Long active in State Board of Health circles, Doctor Harvey left Indiana to take over the duties as Medical Director of the United States Civil Service Commission, with headquarters in Washington.

June 12-16, in Chicago! This marks the date of the annual A.M.A. session. This will not be the streamlined session that has recently prevailed, but will be a complete program, such as has been carried out for years past. A large attendance is expected, and the May sixth number of *The Journal of the American Medical Association* carried the complete program, together with a full list of available hotels. A large number of Indiana men usually attend these sessions, and this year probably will be no exception.

We have visited the capital city on many occasion these last forty years or so, but until a recent trip had never taken time to really see the Medical Center. With Dr. Thurman Rice as a personal guide, we made a complete survey of this interesting spot and were amazed at just what is to be seen out there. We hope to make another and longer visit one of these days, after which we will write our impressions of what the Medical Center really means.

Bernard M. Baruch, the chap who seems to "come through" every time our nation is at war, doing things in his inimitable way and making himself generally useful, now comes out with a donation—a gift of a far different sort. He has set aside over a million dollars for the purpose of providing for the physical treatment of returning soldiers who need rehabilitation in some degree. Dr. Ray Lyman Wilbur heads a special committee which even now is planning its activities in this direction, rather than wait until the soldiers have returned and then see what can be done about it. We long have had great respect for "Barney" Baruch.

President Oliphant still finds himself unable to do much traveling since his recent illness, so President-elect Forster bats for him at all important gatherings. Forster does a swell job of it, but we do miss "Jake."

Some of the OPA groups need corrective measures, it would seem, referring to the matter of granting additional "points" in cases of certain types of illness. Occasionally a board is more than arbitrary about such matters, flatly refusing to accept the statement of such needs when properly made out by the physician. One such case recently occurred in Chicago, creating such a furor that the action of the board was quickly reconsidered and the demands of the patient were properly met.

According to press notices, a down-state physician was sentenced to the Indiana State Prison, and fined something like \$500, following a conviction on the charge of abortion. It was stated that this physician had been arrested some fourteen times, four of which arrests were on an abortion charge, but never before had he been sentenced. Our observation is that confirmed abortionists finally "come a cropper."

Dr. S. B. Sims, of Frankfort, one of the "oldsters" who have refused to sit idly by even though he long since reached the retirement age, is referred to in a story in the *Morning Times* of that city, in connection with a bit of ancient history concerning that paper. It seems that some fifty or more years ago, when Doctor Sims was first establishing his practice, he found some time on his hands and occupied some of it by serving as bookkeeper for the then weekly paper.

Indianapolis reports a shortage of hospital beds in the private hospitals of that city, and a special committee, headed by Dr. Norman Beatty, has been named to investigate the matter. We long have been of the opinion that the bed turnover in hospitals is not always what it should be; in many instances "chronics" are permitted to remain for indefinite periods while other cases are dismissed just as soon as they have reached the period of convalescence when home care will suffice.

News notes have appeared in various newspapers to the effect that certain governmental agencies still have some notions about Socialized Medicine. It is stated that in one area the suggestion was made that certain deductions be made from worker's salaries, which would assure them of having the money to pay for sickness and hospital care. This, however, did not meet with any degree of approval. We may feel more secure about the Wagner-Murray-Dingell Bill, but we will ever have to be on the alert; there are too many New Dealers planning, planning—constantly planning.

Dr. Sumner Koch said that the use of a mask when applying dressings and when in the emergency room is just as important as wearing one in the operating room. Something to think about!

Physicians of Hancock County have revised their fee schedule, a bit upward. Heading the list is "Birth of babies, \$50.00; payable in advance." It will be interesting to learn how the "advance" suggestion works out.

Once more we wish to remind you that reservations for the annual convention, coming within the next few months, are mighty important. Better attend to that little detail right now. Hotels, you know, are well sold out these days, and the chap arriving in Indianapolis without an advance registration is most unfortunate.

Doctor Carleton B. McCulloch, who might be termed "Dean of the Indianapolis profession," was present at the conference dinner. We could not help noting that he holds his years well. When we were a student, more than four decades ago, Doctor McCulloch was a well-established physician, which makes his years rather sizeable, since we are nearing the three-score-and-ten mark.

Time was when a score or more of physicians would leave a sizeable city to attend a medical meeting and nothing was said about it. Now comes a South Bend paper with the heading, "Shortage of Physicians," with a story to the effect that about a dozen doctors had gone to Toledo to attend a one-day meeting.

According to press reports, Dr. Edgar E. Richards, Russellville, recently had a narrow "squeak." He had been out on a country call, and on his way home was somewhat interested in noting the high water along the roadside. Just as he neared a normally small creek, he noted that the bridge had washed out. Fortunately, he was able to stop the car, with the front wheels hanging into space. A local farm tractor served to get the car back on the road.

In the death of Richard Lieber, Indiana has lost its most ardent conservationist. Long the head of the department, he instituted many programs that have continued throughout the years. It was a sorry day when political expediency caused him to be dropped as the head of the Department of Conservation, but that did not cause him to lose his interest in the program that had gone on for many years. One of his greatest accomplishments was the "county forest" movement, one that means much to us today and whose importance will increase as the years go by.

Dr. Norman M. Beatty, long serving as the head of the Indianapolis Isolation Hospital, has resigned from that post in order that he may devote more time to his private practice. The directorship of the institution has been taken over by Dr. Herman G. Morgan, City Health Officer.

On our recent visit to Indianapolis we noted a marked improvement in the behavior of automobile, bus and street car drivers. They now give the lowly pedestrian a chance to complete his street intersection crossing. Not once in a period of two days did we have to jump for our life.

The investigation of the rather mild epidemic of enteritis that struck Lake County some time ago is being continued by the two physicians from the Michigan State Board of Health, this board being especially equipped for such investigations. This is the first occasion for the Michigan men to go outside the state in their studies, and their final report is awaited with much interest.

A rare case of wheat dust silicosis is reported by two Toledo physicians, in the April first issue of *The Journal of the American Medical Association*. This patient was employed as an operator in a large grain elevator, unloading wheat and storing it in bins. He was thus employed over a period of several years, and finally had to stop work. Examination by several physicians resulted in the diagnosis of silicosis.

The problem of medical care in certain of our communities goes on apace. Now we are faced with situations in which a physician is leaving for the armed forces when there already are too few medical men in that community. Two such instances recently have come to our attention, in one of which it was feared the local hospital would have to be closed if a certain physician left the community. Our procurement committees still have a job before them.

Heads of families with children, when about to be inducted into the Army, usually are concerned with the financial aspects of the situation, even though Government checks are sent to the wife each month. In small families, this check all too often does not suffice to cover all the family expense. However, a southern Indiana family, the head of which has been found physically fit for service, should have little care on that score, as indicated by a report from Dr. George S. Row, of Osgood. As we figure it, the monthly check from Uncle Sam will amount to \$280.00, probably more than the monthly income of the average Ripley County family.

The Fort Wayne Medical Center, established many years ago by Dr. Don F. Cameron of that city and later operated by a registered nurse, has been closed for a short period due to a shortage of help. It will be reopened later but will handle only tonsillectomy cases. The medical center is located in the Wayne Pharmacal Building.

Many Indiana newspaper folk are becoming concerned over the medical student problem, about which there presently is much misunderstanding. A recent directive from the Selective Service would indicate that students who had not matriculated by July first, 1944, would be subject to immediate induction. Due to the continuous operation of most medical schools, and the fact that their matriculation dates are not universal, this ruling "messes up things," no end. What with the critical shortage, both for the armed forces and the civilian need, it behooves somebody to see to it that the operations of our medical schools be continued at full capacity.

An editorial in the *Sullivan Times* expresses gratification over the settling of the dispute between the Sullivan County Board of Hospital Management and the Sullivan County Medical Society, which for a time had disrupted the hospital service. "It is to the credit of the doctors that there will be no further interruption of the splendid work they are doing there." This trouble, as you may remember, came about because the hospital board undertook to employ a new superintendent, or manager; a man who had had no hospital experience of any sort, replacing a trained official who had been in charge for many years and whose work met with the approval of every doctor on the staff.

According to an announcement by the Council on Hospitals and Medical Education, recently issued, all hospital records were broken during 1943. Not only were the hospitals filled to capacity, but almost 300,000 new beds were added—even this addition not being sufficient to supply the hospital-care demand. A few smaller hospitals closed their doors, some of them privately-owned, the closing made necessary because the operator had left for the armed service. There were almost *two million* hospital births during the year, certainly a new records and one that would have been further surpassed had there been more hospital bed capacity. Most hospitals set a "duration limit" in obstetrical cases; the mother and babe were required to leave the hospital as soon as possible after the delivery—no more coddling of these cases for the present. One newspaper, in commenting on the report, quaintly says, "If the disposition of the stork to deliver his cargoes at the hospitals continues, where are we in the future to get candidates for presidents born in log cabins?"



President's Page



In all the vast realm of human credulity there is nothing more seductive or any harder to destroy than a medical superstition. Let some individual tell a friend about an old remedy that is full of hocus-pocus and which has no sense or reason about it, and the friend will immediately feel a strong urge to try it. This characteristic is not confined to the unlettered, but is present in the minds of cultivated people as well. It requires some will power on the part of the wiser ones to refrain from the use of a superstitious cure. If the pockets of some of our best friends were turned out for inspection, we would see an astonishing number of buckeyes, shriveled potatoes, and other medicinal amulets.

Last week my neighbor, Jones, told me how his sister's child was cured of asthma. He said that this child had frequent severe attacks, and the doctor was unable to find out the cause of them; neither was the doctor able to prevent the spells from occurring. Then someone told the child's mother that if she would allow the child to sleep with a kitten the disease would be transferred into the kitten. This easy, simple thing was done, and to the wonderment of all the family and friends the child got well and the kitten took the asthma.

That was more than a year ago. The child is still in good health, but the kitten, now grown into a cat, seems to get worse all the time. The two still sleep together, although the mother dislikes to have a sick cat in bed with her child. She is afraid to kill the cat or otherwise dispose of it, for fear that the asthma might then come back into the child. This does seem logical.

Jones told this story with all of the seriousness and credulity with which he might have recounted some of the wonders of radar. He believes it; he has seen the evidence and is convinced. In the beginning he was as skeptical as anyone could be; he regarded the whole thing as ridiculous, but the child got well and Jones is converted. Henceforth, he will go through life looking for children who have asthma, so that he may tell the parents how to treat it. Failures of the remedy will not discourage him nor stop him. He has seen the miracle happen once, and he knows that when all of the conditions are right it will happen again.

Back through the Dark Ages it was believed that persons afflicted with loathsome diseases could cure themselves by inoculating an animal or an innocent person; hence, people with such hideous things as leprosy, tuberculosis and syphilis always sought to give them to a child. Thus, many thousands of children were made victims of these diseases. Centuries of education have not killed this superstition.

Today, stories like this would be fantastic if there were not so many of them. All of us have friends who know someone who was cured of rheumatism by wearing a strand of copper wire around the waist, or who have seen a nosebleed stopped by an incantation, or some sick person healed by a chiropractor, or a case of consumption cured by medicine.

Such beliefs do not rest entirely upon ignorance. They are often present in cultured minds. They are human frailties inherited perhaps from ancestors who lived in caves. Civilization and learning act very slowly upon superstition. It is probable that it will not be eradicated completely until perfect knowledge becomes universal.

Josephant

THE "EMIC" PROGRAM

ROBERT E. JEWETT, M.D.*

INDIANAPOLIS

The Emergency Maternity and Infant Care Program is now known to over a quarter of a million young mothers in the United States simply as "EMIC." Since its inauguration many thousands of letters asking for assistance have been received by the Indiana State Board of Health; letters such as:

"The message I read in today's newspaper about care being offered servicemen's wives in maternity cases was a God-send to me. I have been almost frantic the past few months, wondering how I could handle the situation. Please send me the application form."

And, another less literate letter, but with a touch of humor:

"I want you to send my doctor a slip to fill out and make hit snappy fore I am looking every day to be confined early."

Yes, the storks have been flying in convoys, busier than the Air Transport Command, delivering thousands of babies to the young wives of our fighting men. As a result, the number of newborn babies in this country soared to new heights during the first and second year of this war, reaching a peak in 1943. Last year approximately 15 per cent of all infants were born of young women, average age nineteen, whose husbands had gone to war, leaving them with a limited income, to be sure, to manage and plan alone for their care and that of the unborn babies. Aware of this, as never before in the history of wars, our government took steps to provide specifically for these wives and infants.

On March 18, 1943, Congress passed, and the

President signed, the epochal Act intended and designed to insure the safe birth and well-being of the infants of young men at war, and to provide for good maternity care of the mother without burden or obligation. Perhaps never before was an Act of Congress passed with more high-principled motives, nor with such direct bearing upon the pathos of wives left at home while men go to war. Incident-

ally, it passed both houses of Congress without a dissenting vote, and two later appropriations were carried in the same manner. However, it is doubtful if an act so simply written ever gave rise to so many unforeseen complications because of its intent and limitation. It is also doubtful if health agencies were ever plunged so precipitantly and unprepared into the administration of a program of this magnitude.

The Children's Bureau, of the United States Department of Labor, was given the serious responsibility of interpreting the Act of Congress, defining the services to be provided and intended by the Act, and to allot funds to the states within the limits of the appropriation. The State Departments of

Health, by the same token, were designated to administer the program within these strict interpretations of the Act, to plan and provide for care of eligible wives and infants by physicians, nurses, and hospitals, and to meet directly the multitude of individual problems involved. Each state health agency was also obligated to establish and maintain services with its own resources and personnel, since Congress, in appropriating for medical and hospital care, did not set aside funds for administration.

The Indiana State Board of Health, with the cooperation of the State Medical Association and

Pertinent Excerpts from The Emergency Appropriation Act of the United States Congress of March 18, 1943:

"For Grants to States . . . to provide medical, nursing and hospital maternity and infant care . . . for the wives and infants of enlisted men in the armed forces . . . of the fourth, fifth, sixth and seventh grades . . . under allotments by the Secretary of Labor and plans developed and administered by the State Health Agencies and approved by the Chief of the Children's Bureau. . . ."

Pertinent Excerpts from Regulations and Administrative Rules of the United States Children's Bureau:

"Services may be authorized *when*: At the time of application the individual is the wife, or an infant under one year, of an enlisted man in the fourth, fifth, sixth or seventh pay grade . . . service is without financial investigation and without cost to the patient or family . . . the attending physician has agreed to accept payment only from the State Health agency . . . for services authorized . . . the hospital has agreed to accept payment only from the State Health Agency, at the per diem rate paid by the agency . . . and when it is understood that the patient or family cannot be required by a physician or hospital to pay for any part of either the medical or hospital care to be authorized."

* Director, Division of State Maternal and Child Health, Indiana State Board of Health.

State Hospital Association, made plans early to fulfill its obligation; and, although seriously handicapped by the wartime shortage of personnel, it extended its program for the families of enlisted men to state-wide coverage in June, 1943. When this was announced to the public, there immediately descended a deluge of letters, applications, demands, and sometimes criticisms. They have continued to arrive at an alarming rate ever since, and they run the gamut of human emotions and life's situations. Most are forthright applications for the care that Congress intended to provide, and some are pathetic appeals for assistance not available under this limited program. Some are refreshing and humorous, and others, although sent in misunderstanding, are bitter and critical. Finally, and most welcome, are the touching letters of sincere gratitude.

A sailor overseas applying for his wife, wrote:

"Dear Sirs (or Ladies): Please send me your application form for an expectant mother of a man in service who is a first class seaman. This announcement was made to me from the Children's Bureau, U. S. Department of Labor." He adds a postscript, "P.S. Say, girls—how does a female dress now? We haven't seen any for weeks. I could sit across from you and just stare at you for hours at a time."

One of the tragedies of war was an appeal from a very young girl:

"I am as you might say in a rut. I am sixteen and expect to have my baby by the eleventh of this month. My fiancé couldn't get a furlough home, so wrote me to come to—(Ed. Note: port of embarkation). When I got there he was quarantined to the barracks and could not leave, so we couldn't get married. He is now across and writes that he still wants me to marry him. I have asked the Red Cross for help on the angle of being married by mail, if it is impossible for him to get a furlough home."

This care could not be authorized since the Act specifies "care of wives" and does not provide for unmarried mothers.

Since regulations under the Act limit the services and make them available only to specific ranks and grades, many applications must be rejected. Some persons readily understand and others understandably do not. As examples are these two letters:

"Received your letter this morning about the care of wives and infants of men in the armed services. When I filled out the form my husband was just a sergeant. Now since he has been in England he has been promoted to staff sergeant. So now I'm not eligible for it. Thank you for all your trouble."

This wife of a soldier is really eligible because at the time of application her husband was in the fourth, and acceptable pay grade; a change in status after application has been made does not

affect the authorization. The following letter is from a wife who was not eligible since her husband was in the third, an ineligible pay grade, at the time of application:

"I wish to inform you I received your letter of October 28, and I wish to ask you if you aren't a little late in informing me as to the sentiments you feel toward my child's welfare."

Regulations under the Congressional Act stipulate that "all care authorized must be without cost to the patient or family." Although the State Board of Health does not specify the extent of services to be rendered, patients sometimes pay for unusual or luxury care, and thereby cancel authorizations. This may be accepted touchingly without complaint, as in this letter:

"The enclosed authorization for Maternity and Infant Care is being returned to you unused. Under your care I was placed in a pleasant six-bed sun room, and under ordinary conditions the service would certainly have been very satisfactory. However, our baby was not alive and the mental anguish I suffered at three-hour feeding intervals was unendurable. That evening I was moved to a private room with the understanding that I would pay for this service and your plan was not in effect. I am sorry I could not take advantage of this assistance but thank you for the offer."

This sailor chose to provide and pay for unusual hospital and medical services for his wife, since it could not be authorized by the government, but he expresses restrained and understandable bitterness at the limitations:

"Confidentially, when this event is over I'm going to see to it that the doctor is paid in full, even if I have to borrow, and he's going to get an extra ten dollars. Should another service man come along under like circumstance—you exert just a wee bit of effort and take care of his interests—because maybe that sailor may even give his life in protecting yours."

The administration of a program limited by law in such a way as to seem discriminatory to some entails the swallowing of many bitter pills. Nevertheless, some good is accomplished and expressions of gratitude, such as the following, are a welcome relief:

"Your kind letter stating that you would authorize payment for my medical and hospital care was received just a few minutes ago. There were tears of joy in my eyes when I read your letter because truly my heart was very heavy when I thought my application had been rejected."

"My husband and I had a sweet baby girl last September, and had it not been for the wonderful medical care given to wives of servicemen, I don't know what we would have done. I can

never tell you just how much I have appreciated everything."

"Recently you were kind enough to authorize care in the Riley Hospital for my sons. Since their father is in the Air Force and at present overseas, I especially appreciate your favorable decision by helping me at this time by making the special servicemen's fund available for my sons. I sincerely thank you."

Who is eligible for care under this program, what services are available, and how may application be made?

The following is a brief outline of these points (for detailed information on any specific point, write the Division of Maternal and Child Health, Indiana State Board of Health, 1098 West Michigan Street, Indianapolis 7):

Eligibility: Any woman, or infant under one year of age, irrespective of legal residence or financial status, whose husband or father is an enlisted man in the armed forces, of the fourth, fifth, sixth or seventh pay grade at the time of application, is eligible.

Services and care intended by the Act of Congress: (1) Complete care of the wife during the maternity cycle only, including all medical and hospital obstetric care during the expectant period, at the time of delivery, and for the normal recovery period six weeks after delivery. This includes with the application for maternity care, care of the normal newborn infant for two weeks after its birth. (2) Complete medical and hospital care of sick infants from birth until the first birth anniversary. (3) Special and additional services for a wife or infant (these must be requested immediately as needed by the attending physician). Qualified medical and surgical specialists in private practice to act as consultants to the attending physician; anesthesia and surgical assistance services by physicians in private practice; bedside nursing home visits provided by public health nursing agencies; special duty bedside nursing care by registered nurses on the day of delivery, or for a period of four days during a critical illness; ambulance service when necessary and not otherwise available; drugs, x-ray services, supplies and appliances when provided by the attending physician or ordered by him from persons or firms other than hospitals (contracts have been made with hospitals for such services); immunization of infants for smallpox, diphtheria, and whooping cough; care for infants over one year of age at the Riley Hospital for Children only for selected or critical conditions.

Making application and requesting special services: Initial application for maternity care must be filed before care is given or at the time first care is rendered, and a separate application must be made for pediatric care of a sick infant. Application forms may be obtained from the Indiana State Board of Health, and usually from local

physicians, Red Cross Chapters and health and welfare agencies. (Any message, a letter, postcard or telegram will establish the effective date for authorizing care until the proper application form can be obtained and submitted.) The applicant must fill out the form, stating accurately the information which establishes eligibility, such as the serviceman's serial number, rank, salary grade, and post of duty. The attending physician must specify the services requested and sign the application form. The applicant is then responsible for promptly mailing it to the Division of Maternal and Child Health, Indiana State Board of Health, 1098 West Michigan Street, Indianapolis 7. Requests for special or additional services, as outlined above, must be made immediately when needed, by the attending physician. This may be done by letter, telephone, or telegraph, or on special forms provided for the various services.

How does the State Board of Health assume the obligation and authorize care? If applications or requests are made promptly, if the requested care is covered by the program, and if the applicant is eligible, full responsibility is assumed by the State Board of Health, and no charge can be made to the patient or family for care requested and authorized (in accordance with the Act of Congress and regulation of the United States Children's Bureau). When an application for care is delayed through misunderstanding or oversight, it will be reviewed, and if it is accompanied by a statement from the parties involved which (1) establishes an acceptable reason for delay, (2) indicates the care already given and date of first service, and (3) shows that no payment has been made during the period to be covered by authorization, such authorization will be made when warranted.

When a request or application is acceptable, a notice of the authorization is sent to each of the parties involved. A reasonable delay may be expected due to the present necessity of checking and due to the tremendous load of correspondence handled by the State Board of Health, but if the notice of authorization has not been received within fourteen days, a "follow-up" should be made.

How are obligations met by the State Board of Health? After a report of authorized services has been received by the State Board of Health, and if it is clear and accurate it is cleared for payment.

Since the fees for services and hospital rates are, for the most part, privileged information, any interested physician, nurse, hospital, firm or agency should make direct inquiry to the State Board of Health for this information.

Following the procedures outlined, and within the strict limitations of the program, thousands of wives of our fighting men have applied for assistance in Indiana. A tabular report shows the care authorized, the number of cases for which care has been completed or closed out, the total cost, and the average cost per case. This report does not begin to show the really great number of inquiries, letters, procedures and controversies involved in the over-

all administration of the program, and the very small staff concerned with administration refuse even to dream of compiling such a report.

REPORT OF OBSTETRIC AND PEDIATRIC CASES AUTHORIZED, CASES COMPLETED, AND COST OF CASES COMPLETED UNDER THE EMIC PROGRAM IN INDIANA, THROUGH MARCH 31, 1944

	Maternity Cases	Pediatric Cases	Total
Number of cases authorized..	9,286	1,262	10,548
Number of cases completed and closed out.....	3,878	531	4,409
Cost of care for cases closed out	\$355,914.51	\$ 19,203.18	\$375,117.69
Average cost of care for cases closed out.....	91.78	36.16	
Combined average for both Maternity and Pediatric cases			\$ 85.08

The facts bear out that a considerable amount of assistance has been afforded the wives and infants of men in the armed forces. Nevertheless, like any public assistance program affecting a large population group and persons and agencies providing services, the program has been subject to misunderstanding and misinterpretation.

Why should a program, established by the government of our people, conceived on such a high plane of motivation and with such a direct effect upon the morale of our fighting forces, seem to accomplish its intent, and yet remain subject to criticism in many instances? The answers are that the amount of an appropriation fixes certain administrative restrictions; the Act itself, and its legal interpretation, may react to the advantage of certain persons or groups and seem unsatisfactory or discriminatory to others; and finally, the administration of the intended program may entail unforeseen difficulties. All of these possible conditions and consequences have occurred.

A brief analysis of the excerpts from the Act of Congress and the Regulations and Rules of the United States Children's Bureau will serve to explain why very specific services are provided for, why there are certain definite limitations, and why it is all too easy for some to misinterpret the intent of the Appropriation Act and fail to comprehend the administrative problem which faced the State Board of Health. For instance, the maximum fees and rates paid for services have frequently been a "bone of contention." Actually, payments must be fixed within certain limits. Since the amount of the appropriation is limited, its expenditure must be controlled and made to cover the case-load demand. Increases in payments per case cannot be made until Congress increases the appropriation.

The wording of the Act and rules and regulations based on its interpretation predetermine administrative policies and methods of providing care. For example, some have contended that administration would be much simpler if the wife received the prescribed amount of money directly, thus permitting her to make her own arrangements for care. This might well be true, but, the words of the Act,

"to provide medical, nursing and hospital care" mandate that the delegated authority must spend the public's funds for just those services. A direct allotment to the applicant would not guarantee the purchase of the care specified. Every other clause of the Act may place just such finite limits on a phase of administration. Laws are the actions of the elected government, actions by proxy of the people themselves, and officers of the government must provide administration according to the letter of the law.

The administration of the "EMIC" program is governed by the law and the funds available, and these factors are responsible for the difficulties and misunderstandings in part, but not entirely. The State Board of Health has had to call entirely upon its own limited resources to build up a large clerical and accounting staff when all types of personnel are at a premium, and to establish an administrative setup without precedence in public health services. Every worker involved has felt duty-bound to strive unstintingly, and all have put in many hours of uncompensated overtime; but even with such a mighty effort it has been difficult to keep up with a seeming tidal wave of applications, queries, and correspondence. This, also, has undoubtedly added a measure to the confusion. Nevertheless, progress has been made, and all concerned have been sustained by the knowledge that they are working hand in hand with the physicians, nurses, and hospitals in a program to sustain the morale of the armed forces.

The physicians of our state, in particular, have contributed their skill generously, and in return for only moderate recompense, to this wartime program for the families of our fighting men. To pay them homage, the Surgeon Generals of the Army and Navy released a message March 25, 1944, quoted in part as follows:

"The morale in the armed forces is being raised and our fighting men go overseas with greater confidence in the security of their families because of this wartime program.

"We who are responsible for the health and medical care of the men in the armed forces are grateful to you *physicians* who are participating in this program of care for the wives and infants of these men. You are sharing with us our normal peacetime responsibility of caring for the families of our men, and so are making it possible for us to give our best efforts to the men themselves.

"Your contribution is an invaluable aid to us in the prosecution of the war, and we count on your carrying this program forward in the year to come with the same generous spirit you have shown in the past year.

"ROSS T. MCINTIRE,
Vice Admiral, M.C., U.S.N.,
The Surgeon General of the Navy.
"NORMAN T. KIRK,
Major General, U.S. Army,
The Surgeon General."

NURSES NEEDED FOR NURSING ON THE HOME FRONT

ETHEL R. JACOBS, R.N.*

INDIANAPOLIS

With commendable cooperation from Indiana's physicians, the classification and assignment program of the War Manpower Commission and the Indiana State Nursing Council is making splendid progress. The program is being carried on by the special Procurement and Assignment Committee of the State Nursing Council for War Service through local nursing councils.

The State Procurement and Assignment Committee is indebted to the members of the medical profession in Indiana for the willing and helpful cooperation it has extended. With continued participation on the part of the registered nurses, the physicians and the public, the State Nursing Council for War Service believes that the two-point goal of this program will be successfully achieved. That goal is to insure the Army and Navy of the orderly induction of an adequate supply of vitally needed nurses to care for the sick and wounded fighting men, and to guarantee the civilian population a sufficient number of trained nurses to staff the hospitals and care for serious cases of illness in the homes.

In their efforts to achieve the two-pronged goal, Indiana nurses are mindful of their responsibility to the physicians. They realize the terrific case load the doctors who have been designated as necessary on the home front are carrying, while their ranks have been depleted by the large numbers who have been accepted for service with the armed forces. The nurses want to help.

The State Nursing Council for War Service and its Procurement and Assignment Committee are making every effort to prevent the removal of necessary nurses from the offices of busy medical practitioners. At the same time the committee is making every effort to see that trained nurses needed to maintain services in the hospitals are not engaged in less important activities, especially in private-duty cases where there is no actual need for the service of a registered nurse.

The importance of maintaining in the hospitals minimum staffs essential for safety is considered paramount, and the State Nursing Council for War Service is asking cooperation of all interested persons in seeing that this critical need is met. Many Indiana hospitals are reported to be understaffed, and, accordingly, the nurses in such institutions are overworked.

The committee feels that the physicians can be of great assistance in the present program by using their persuasive powers among registered nurses in:

1. Urging that nurses whose qualifications make them of greater importance in the war effort on the home front than in the armed services accept that fact and not insist upon enlistment in the Army or Navy Nurse Corps.

2. Urging patients not in actual need of registered private-duty nurses to refrain from attempting to employ registered nurses.

3. Reminding registered nurses that Indiana has met its quota of nurses needed for the Army and Navy for the first six months of this year, and that Indiana is not morally obligated to furnish additional nurses to the armed services before July.

4. Advising qualified instructors and administrative-type nurses who are seriously needed in the education of student nurses and in maintaining hospital services that under present conditions it is equally as important for them to serve on the home front as to serve with the Army and Navy.

One of the most serious problems faced by the state committee in carrying out its program has been the continued extreme patriotism on the part of a very large number of registered nurses. These nurses have failed to realize that it is as important to maintain a healthy, active home front as it is to minister to the needs of the armed services. So many Indiana graduate nurses have responded to the desire to enlist in the military or naval forces that Indiana on April first had exceeded its six months' quota for the armed services by fourteen volunteers.

In many instances older and more experienced nurses who possess requisite qualifications for instructors or executives, the type so seriously needed on the home front, have insisted upon volunteering for duty with the Army or Navy Nurse Corps. This group can not now be replaced on the home front. They are needed to train student nurses and to fill executive positions in hospitals. The State Nursing Council for War Service asks that they be made aware of their greater importance in civilian life and expresses the hope that doctors will aid by advice and persuasion in encouraging them to remain in necessary employment at home. The need of the Army and Navy, today, is for younger and physically more active nurses, but Indiana has contributed more than its share, and this age group is needed at home for staff nursing positions.

Likewise, the State Nursing Council for War Service will appreciate the cooperation of the physicians in encouraging the new graduates who are anxious to enlist in the Army or Navy Nurse Corps to cooperate with their local Procurement

* Chairman, Procurement and Assignment Service for Nurses, War Manpower Commission.

and Assignment Committees in the committees' effort to meet both the home-front and armed-service needs. With the existing serious need for skilled nurses in most of Indiana's cities and many towns, in hospital and critical private-duty cases, and with the state's quota for the first six months of this year exceeded by fourteen volunteers, the State Nursing Council for War Service hopes to discourage any additional armed service enlistments before July first. Equal to the needs of the Army and Navy, it is equally important that adequate care be assured for the health of war industry workers and others necessary to the war effort in civilian life. Examples of the crisis faced by several Indiana communities are seen in the following excerpts from letters received by the office of the State Committee on Procurement and Assignment, State Nursing Council for War Service:

"In reply to your letter concerning unfilled essential positions in . . . and . . . counties, we now have two vacancies on the hospital staff. Two members of the staff were inducted into the Army in March, and one is to be inducted this month. (One position has been filled.) One of the night nurses plans to quit next month, so we may have a third vacancy. Two members of the staff are here because their husbands are stationed at . . . Field; they are not very dependable as their husbands may be transferred any time."

"We have had four nurses assigned for duty in the armed forces since January 1, 1944; three to the Army and one to the Navy.

"We also have the following unfilled positions at . . . Hospital: assistant night supervisor; two positions in surgery; four general-duty positions on the floors on day duty."

"Our nursing situation is now at a critical stage and unless we are able to obtain nursing help very soon it may be necessary to close our hospital; hence, any immediate help you can give us will be greatly appreciated."

"In a recent letter you asked what essential positions are now unfilled in our territory. The only unfilled essential positions are those of staff nurses at the hospital. The administration estimates the need at from ten to fifteen nurses."

"We are badly in need of a county nurse and funds are provided for one, but none are available. We are also in need of two or three general-duty nurses and could also use a few private-duty nurses at times."

"I have inquired at the state tuberculosis sanatorium and found they have three unfilled positions. These are for one day supervisor and two night charge nurses. This would not only be essential but would give them their usual graduate help."

"Since we have gone on short handed so long, I hardly know where to start. Of course, every hospital could use many private-duty nurses, if they were available. At present we have very few. The doctors feel that one nurse should not be tied up with one patient when there are so many who need care.

"Of the two hospitals in this city, one could use at least three more general duty nurses and another hospital needs four more for general duty and one for surgery, and perhaps four for private duty. This, of course, is a superintendent's dream, and I feel sure that we can not hope to have much more help until the war is more nearly over. This will give you a picture of some of our needs, but this report applies to the hospitals only."

"We need a minimum of two nurses immediately or else we will be obliged to cut bedside nursing very soon. Our nurses are carrying too heavy a load. Will you please refer this request to the proper person in charge of Procurement and Assignment of the State Council for War Service?"

"We have scoured our own community through our local council, hospital schools of nursing, et cetera.

"We are wondering if perhaps we are now contributing too liberally from our county to military service?"

"Our situation is critical. Our organization was loyal and cooperative. We took on married nurses as vacancies occurred instead of pursuing our regular policy of using married nurses as relief nurses. Our experience with the employment of married nurses in permanent positions has been almost devastating. Within four months three became pregnant, and for reasons of their own health were obliged to leave on no notice whatsoever. All three are excellent public health nurses.

"Our industries are employing a considerable number of nurses. Could it be that some are heavily staffed considering the fact that the type of work is only in the nature of first aid? Do those nurses do too much routine clerical work?"

"Are school staffs larger or smaller?"

"We did not increase our staff to meet the increased population given as a minimum of 25,000. We have stretched our service to take on health supervision of Lanham Act nurseries and, of course, care for increased maternity work, et cetera. Our people can not be hospitalized as can the population of Indianapolis. Our hospitals are too small."

"Before Pearl Harbor we had a regular graduate nursing staff of fifty-six. It is now twenty-five, in addition to twenty-four nurses' aids, most of whom we have trained here. Our hospital accommodates seventy adult beds and fifteen bassinets. The graduate staff is now distributed as follows: night nurses—7 (to serve on three floors), surgery nurses—5, and day nurses—13 (to serve on three floors). All are on eight-hour duty, six days a week. Every day our great problem is to secure nurses to fill vacancies in our personnel due to illness or some unavoidable cause which arises suddenly. This is not only true of the nursing staff but is also equally true of the unprofessional groups.

"Often we call several hours and are unable to secure anyone to help us. This does not happen

because there are no graduate nurses, but many of them are married, staying in their own homes, and do not wish to work. If some plan were devised whereby these inactive, qualified married nurses might be persuaded to assist the hospitals for the limited duration, I am sure that nurses would be available immediately for essential civilian nursing positions."

The above calls to mind another suggested way in which doctors can be helpful. Many doctors are acquainted with the inactive nurses in their communities. Perhaps a call from a doctor with whom they have served in the past will do much to bring a nurse possessing valuable training and experience back to active service at this time when all are so critically needed.

PATIENT MUST HAVE PRESCRIPTION TO OBTAIN SULFA DRUGS

J. C. SCHNEIDER

Director, Division of Food and Drugs, Indiana State Board of Health

INDIANAPOLIS

It is the consensus of qualified experts that sulfa drugs are a valuable aid in the treatment of several serious disease conditions when the dosage is properly adjusted to the requirement of the individual patient and frequency of dosage and duration of treatment are intelligently and expertly directed. It is further the consensus of such experts that when used under other conditions it is a dangerous drug, capable of causing serious injury and even death. In addition to these apparent dangers, recent facts have demonstrated that if stricter control is not placed upon the promiscuous sale and use of sulfa drugs the efficacy of the drug will be reduced to a point where it will be of little or no value in treating certain diseases. This would be most unfortunate in view of the fact that the drug has literally performed miracles in the past.

In the light of these facts, careful consideration has been given to the status of sulfa drugs under the provisions of the Indiana Food, Drug and Cosmetic Act which deals with traffic in dangerous drugs. Section 18-J of the Indiana Act states in effect that drugs which are dangerous when sold indiscriminately and without written prescription are in violation of the Act.

Certain other drugs fall within the same category as the sulfa drugs. As example of drugs which are considered dangerous when dispensed otherwise than on prescription, the following have been mentioned: aconite, aminopyrine, barbiturates, benzedrine sulfate (for internal use), cantharides (for internal use), chrysarobin or goa powder, chrysophanic acid, cinchophen, neocinchophen, and other cinchophen derivatives, colchicine, colchicum, emetine, phosphides, phosphorus, radium, sulfanilamide, sulfapyridine, sulfathiazole, tansy, tansy oil, thiocyanates, thyroid, and the anthelmintic drugs—carbon tetrachloride, tetrachlorethylene, male fern (aspidium), santonin, wormseed oil (chenopodium oil) and thymol.

A recent survey by representatives of the Indiana State Board of Health disclosed the fact that sulfa drugs are being dispensed too frequently in Indiana

without prescription. As a corrective measure the cooperation of the pharmaceutical profession, through its Association, has been solicited and received. Through the Association a special bulletin has been sent to each retail drug store in the state, advising them that a written prescription is necessary to dispense sulfa drugs or any other drugs considered dangerous when used without the proper medical advice of a physician. We have every reason to believe that henceforth a physician's prescription will be demanded of their customers when requesting any of these drugs.

The survey referred to above also included an attempt to determine why such drugs were sold without prescription. The reasons given were principally due to ignorance of the laws and the fact that physicians did not in all instances furnish their patient with a prescription. We are cognizant of the fact that the physician during the present emergency is overworked and must of necessity resort to certain unusual practices. The fact, however, remains that unless the physician's patient has a prescription it places the pharmacist in jeopardy of the law if he complies with the physician's verbal order and places the patient in the embarrassing position of being refused a badly needed drug. The patient will also have to take the time and go to additional expense of making a second office call. The patient is not familiar with the dangers resulting from improper use of sulfa medication, and because the physician has given verbal instructions to go to the corner drug store and buy a dozen sulfathiazole tablets he is inclined to resent the pharmacist's refusal to supply the necessary drug.

It is only through cooperation of the medical and pharmaceutical professions that this public health problem can be satisfactorily solved. With each profession assuming its proportionate share of responsibility there will be very little need for drastic action, and what is probably more important the efficacy of a most important drug will be preserved.

SIXTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

The following are excerpts from the paper read before the Sixth Annual Congress on Industrial Health, held in Chicago on February 15 and 16, 1944, by Stanley J. Seeger, M.D., chairman of the Council on Industrial Health, of the American Medical Association:

"The problems of industrial health are not static. Science gives new knowledge. Medical concepts change and industry also changes, not only in its techniques but in its attitudes. The perfection of methods of treatment and prevention by physicians and hygienists and engineering specialists has, in the past, been followed by a lag in their utilization by the rank and file of practicing physicians who care for a large segment of the industrial population. The difficulties of establishing industrial health programs in small plants characterize the manner in which science has outstripped the advancement of social and professional organizations which would make possible the fullest utilization of our knowledge. This lag has been caused by several factors, one of the most important of which has been the extremely rapid development of industry. Another has been the failure of medical educators to train students, both undergraduates and graduates, in preventive medicine and public health activities, and to assign to industrial medicine the place which its importance justifies.

"The experience of a number of medical schools amply demonstrates that reasonable acquaintance with the subject can be provided at modest expense. The all-important requirement for improved instruction is a unified plan which assigns over-all responsibility to one single teaching division, preferably preventive medicine and public health. The interest of the Council in education in industrial health has been expressed by (1) the original report of its committee on scope; (2) the formation of a sub-committee on education; (3) articles on industrial medical education in the special industrial health issues of *The Journal of the American Medical Association*; (4) instructions to state and county committees; and (5) development of a syllabus for undergraduate and graduate teaching. The response of medical educators has been encouraging not only to the program of this Council but also to the efforts of the American Association of Industrial Physicians and Surgeons.

"At the present time, when medical and health plans centering about industry and when hospital relationships are matters of such serious concern, this basic principle, the essential medical nature of health activities, should more than ever be brought up for discussion. This principle is basic, and it is vital to the problems which are pressing for solution today. We spend much time in discussing medical relationships in hospitals and in analyzing medical features of various hospital plans and their effect on medical practice. Why is the fact not brought out that in the majority of hospitals in America today the medical staffs do not control the medical policies and in many instances do not know the names of the lay individuals who decide the policies of the institutions in which they practice?

"The hospital has been a normal nucleus about which efforts for medical care service have revolved. With the acceleration of all human effort during the war, the tremendous industrial expansion, the shifting of population, the limited number of physicians, the difficult problems of housing and sanitation and transportation and nutrition, there has come as a matter of course a great impetus to the study of industrial health programs and of medical care plans. In both the hospital and industry the physician is dealing with corporations. In both a third party is interested in certain phases of medical

care. In industry the corporation has a legal obligation to assume certain medical responsibilities. In both the hospital and industry we have a growing interest in the expansion of health service on the part of the corporation. In the case of industry this interest is being augmented by labor organizations. In viewing industry we find that in contrast to the hospital, we are dealing with a tangible organization where names are known and where, in most instances, the directing heads are residents of the communities in which the physician practices. The contacts necessary for the physician to organize health activities exist. It is our concern that the physician should be the central figure in the organization which delivers such service. While we have perhaps become conditioned to look for master blueprints, we should remember that the minimum requirements for health services in industry have been defined and the principles involved are well known and well understood. The delivery of competent health service in industry demands that the position of the physician in the structure of industrial organization be clearly visualized and that his relationship to other interested skills should be clearly analyzed.

"With the increased interest in medical care plans has come a discussion of the desirability of the organization, on a wide scale, of medical groups or clinics. Clinic or group practice has become such a popular phrase and has been so widely recommended, particularly by some industrial leaders, that it would seem a logical step to re-examine the fundamental professional relationships involved and the methods of business organization of clinics under the principles of medical ethics. The professional relationships and business relationships in groups and clinics are generally accepted as ethical and sound, but the basic principles of organization are not too well understood. A critical analysis of this type would be most helpful in clarifying the situation in determining the desirability of accelerating the development of this type of medical entity on a broader scale.

"The contributions of a scientific nature, which have been made by the various councils, bureaus and scientific sections of the American Medical Association, are almost limitless and these resources are at the service of those interested in industrial health programs. This Council has stimulated in the various scientific sections the creation of committees on industrial health and several have made noteworthy contributions. The activities of some of these special committees are reflected in the present program.

(1) The physician should be the central figure in health activities whether in the field of clinical medicine, public health or preventive medicine.

(2) The problems of medical service in this country are being solved in many areas by developments which center about industry and are essentially on a grass roots basis.

(3) In a majority of hospitals in America the staff has no control over medical policies. The organization of many hospitals is obscure or so ill-defined that medical staff organization can not contact the lay individuals who control policies.

(4) The organization of industry is such that it lends itself to a logical and ethically sound approach to the development of health programs.

(5) Because of the widespread interest in this type of practice, the practical application of the principles of medical ethics to the professional and business relationships of medical groups or clinics should be re-studied and clarified and defined.

(6) The Council reports progress."

SUPPLEMENTAL FOOD RATIONS

To make sure that ill persons quickly receive such extra amounts of rationed food as they may need, special treatment will be given applications for extra rations where the individual is suffering from an illness which usually requires additional amounts of such food, according to an announcement made by the Office of Price Administration. This new provision became effective April 6, 1944.

Up to the present, anyone whose health required more rationed food than the regular ration provides could request his local board to issue a supplemental ration. This procedure sometimes resulted in delay in issuing supplemental rations to those who had a legitimate need for more rationed food.

To overcome these difficulties, local boards will issue extra rations for reasons of health only where the individual is suffering from a type of illness generally accepted as requiring more rationed food. Application may, of course, be made for additional rations for other illness, and local boards will, except in cases of emergency, pass these on to the OPA District Office for consideration.

Illnesses which automatically make a person eligible for more food were determined for OPA by the Medical Food Requirements Subcommittee of the National Research Council. Individuals suffering from these illnesses will receive additional rations on the basis of needs for ten-week periods.

Where additional amounts of rationed meats,

fats, and oils are requested, the extra ration will be acted upon by the board if the individual is suffering from "diabetes mellitus, active tuberculosis, chronic nephritis (nephrotic type), cirrhosis of the liver, severe hepatitis, chronic suppurative diseases (this group includes empyema of the chest cavity, osteomyelitis, extensive suppurative lesions of soft parts, subcutaneous tissues or muscles, and those infections in which there is profuse pus formation), severe burns, gastro-intestinal lesions (including postoperative cases involving operations on the stomach, intestines or colon for ulcers or cancer), or pregnancy." Extra allotments of processed foods will be issued by local boards when the applicant is suffering from diabetes mellitus, or active tuberculosis.

When a supplemental ration is requested for an illness or condition of health other than those mentioned, the board will act upon the application only in cases of emergency. All others will be sent to the District Office for action.

All applications for supplemental rations should contain a written statement, signed by a doctor, which gives a diagnosis of the applicant's illness as well as an estimate of the amount and type of rationed food required for the succeeding ten weeks. In cases of pregnancy, this statement may be prepared by a public health nurse.

(Amendment No. 20 to Revised Ration Order 13—Processed Foods—and Amendment No. 122 to Ration Order 16—Meats and Fats—both effective April 6, 1944.)

ABSTRACT: ACCEPTANCE OF BLOOD GROUPING EVIDENCE BY AMERICAN COURTS

When an American court fails to accept authentic blood test evidence it would not seem to be carrying out its responsibilities as an administrator of justice. *The Journal of the American Medical Association* for March 18 says in an editorial on "Blood Grouping Evidence." *The Journal* says:

"In courts of law any child born in lawful wedlock is presumed to be legitimate, and from the earliest days this presumption of legitimacy has been an extremely weighty one. Under the law of the 'four seas' an English court once held that a child born in England was legitimate even though it appeared from the . . . evidence that the husband resided in Ireland during the whole term of his wife's pregnancy and for a long time previously, because Ireland was within the king's domain.

"In a [recent English] divorce proceeding the husband requested a blood test, which proved that he was not the father of his wife's child. (Both husband and wife belonged to type M, while the child belonged to type MN.) The test is now generally accepted as proof that a certain man could not have been the father of a certain child. In his decision the judge remarked that at first he was inclined to think, *albeit very reluctantly*, he was bound in law to accept the result of the blood group test, not because as a man he thought the doctor was right but because as a magistrate he thought the evidence was legally convincing. However, since the legal presumption of a child born in wedlock being legitimate is very strong, he finally decided not to upset it solely on scientific evidence. Evidently this judge preferred the comfort of adherence to tradition.

"The reaction of American courts to blood test evi-

dence has been reviewed in a book that has just appeared. The problem of paternity arises most frequently in so-called "filiation proceedings," less often in divorce actions. In the former the child is born out of wedlock and the mother designates a certain man as father and an action is started to compel him to support the child. In such cases, when the blood tests prove that the defendant is not the father of the child in question, the courts usually accept this result without hesitation, probably because an illegitimate child is involved. (It is highly significant that the woman usually confesses to indiscretion with other men besides the defendant after the results of the blood tests are divulged.) In uncontested divorce actions the reaction of the court is likewise favorable. In contested divorce actions, on the other hand, judges apparently prefer to accept the testimony of the wife rather than the objective blood test findings, so that in courts of this country, just as in England, not much progress has been made away from the law of the 'four seas.'

"No doubt the first duty of the court is to see that truth and justice prevail. In the English case cited, the court proudly announced the happy outcome—the husband agreed to make a home for wife and child and accept the child as his own. However, a reconciliation might have been effected without resorting to such subterfuge, because husbands in the past have been known to forgive erring wives and to accept children not their own. When a court refuses to dissolve or annul a marriage of two incompatible people, even though there is scientific proof of the wife's deceit or fraud, as has happened in a number of cases in American courts, the court would not appear to be carrying out its responsibilities as an administrator of justice."



Military News



Captain Abraham Owen, of Attica, is now serving in Australia with the Army Medical Corps.

Captain William A. Shuck, of Madison, is now serving overseas. He has a San Francisco A.P.O. address.

Captain Fred K. Allen, of Fredericksburg, is now stationed at Camp Edwards, Massachusetts. He was formerly at Carlisle Barracks, Pennsylvania.

Major Alan L. Sparks, of Indianapolis, has been transferred from Billings General Hospital, Fort Harrison, Indiana, to Fort Knox, Kentucky.

Lieutenant Commander Erwin Blackburn, of South Bend, has been assigned to the Naval Station at Crane, Indiana. He has been stationed at Notre Dame for the past few months.

Promotion of a South Bend physician, Dr. C. C. Terry, to the rank of commander has been announced. Congratulations, Commander Terry!

Major Roger W. Brookie, of Flora, is located at the Station Hospital, Camp Davis, North Carolina, having been transferred there from Nashville, Tennessee.

Transferred from Camp Bowie, Texas, Captain James N. Topoligus, of Bloomington, has a New York A.P.O. address.

A letter received from Major Karl M. Beierlein, of Fort Wayne, indicates that he has been transferred from Camp Campbell, Kentucky, to the Veterans' Administration at Dayton, Ohio.

Dr. Wendell C. Kelly, of Indianapolis, has been promoted to a major. Major Kelly is now serving in Naples as chief of Dermatology, with the 36th General Hospital, which is from the Wayne University in Detroit, Michigan. Major Kelly states that he has seen C. O. McCormick, Jr., and Captain Russell Arbuckle and several other of his classmates.

Captain A. R. Chambers, of Fort Wayne, seems to have returned from a foreign station, as indicated by his New York, Army post office address, and is now at the Percy Jones General Hospital, in Battle Creek, Michigan.

Captain Orva T. Kidder, of Fort Wayne, is in charge of the X-ray Department of the Armed Forces Induction Center in Cleveland, Ohio. Captain Kidder formerly served in the African theatre of war, but was invalided home and reassigned to Cleveland upon his recovery.

Dr. Charles J. Cooney, of Fort Wayne, has recently been advanced from captain to major in the Army Medical Corps. Major Cooney is head of the Urological Section of the Regional Hospital at the Columbia Army Air Base, Columbia, South Carolina.

Major S. E. Bechtold, of South Bend, is the surgeon and commanding officer of the station hospital at the Rome Air Depot, New York. Being a staff surgeon for the Rome Air Service Command, he has six hospitals under his jurisdiction. He is quoted as saying that in making his rounds, he flies to each place—"tough, isn't it?"

The following is an excerpt from a letter received from Commander Arnold H. Duemling, of Fort Wayne: "Just a note to say 'Hello,' and to tell you of my new assignment, which is with a cruiser group in a Task Force, in the Pacific. Our Force has a splendid group of doctors; we have had many conferences and expect to be able to handle our end of it after the smoke clears away. Regards to all."

"We are now in the midst of a pleasant season in Sardinia, after having spent a rather tiresome winter," is the news from Captain Theodore J. Bruegge, of Kokomo. "Our building leaves nothing to be desired, and we have been comfortably enjoying our work, in contrast to the discomforts of last winter and summer experience in Tunisia. We are indeed fortunate," he said.

After spending a year on Attu Island in the Aleutians, Major Boyd Burkhardt recently returned to the United States. On April tenth he spoke before a local organization at Tipton, giving an interesting account of his experiences and illustrating his talk with several photographs taken on Attu, including one of a salmon he caught which was so long it had to be lifted from the stream sideways, according to the *Tipton Tribune* of April 11, 1944. "Major Burkhardt explained, however, that the stream was but one foot in diameter at the surface, with the main channel running beneath the snow."

Dr. O. Raymond Russell, of Frankton, has been promoted to a captain in the Army Air Force. Captain Russell has been serving in the African and Italian theatres of war.

Dr. V. F. Tremor, of Indianapolis, has been made a lieutenant colonel in the United States Army. A veteran of World War I, he has served as chief surgeon at the Veterans' Hospital in Indianapolis.

Advanced from lieutenant commander in November, Commander A. P. Rhamy, of Wabash, did not learn of his promotion until March, when the commission finally caught up with him aboard a carrier in the Southwest Pacific.

After spending nine months on the Southern California desert, Major A. B. Scales, of Oakland City, was sent overseas in January. In February he was promoted to the rank of major. Major Scales is now serving as neurosurgeon for an evacuation hospital somewhere in New Guinea.

Dr. Robert Peacock, of Indianapolis, has received a captaincy at the Army Air Base Hospital in Rapid City, South Dakota. He graduated from Randolph Field, Texas, as flight surgeon, and was transferred to Rapid City where he received his commission March tenth.

Captain Floyd S. Martin, of Goshen, has been in England since September, 1943. He has seen much of the south coast of England and many historic points of interest. He states they are well-equipped for the future, having many five-hundred-bed hospitals with only a limited number of patients at present.

We take the privilege of reprinting a letter published in *The Bulletin* of the Indianapolis Medical Society. Incidentally, Dr. Richard H. Appel, of Indianapolis, has recently been promoted to a commander. Congratulations, Commander Appel!

"I was moved up here the middle of last December, and am now in the New Hebrides. As you can easily guess, this part of the world features heat and dampness. The coral reefs and their multi-colored myriads of fish live up to their glamour, but there the glamour ends. The tropical nights can be beautiful, but do you drink alone?"

"I'm sleeping in a bunk which Paul Beard vacated a week before I arrived, but have not had contact with him. Saw Roy Smith 'down under' in December, and found him wearing a monocle and having acquired the British accent.

"My promotion, I'm sure you noticed it, reflects the thought that the longer time in the service, the more the silver hairs on the head and gold on the sleeve."

Captain Robert A. Staff, of Rockville, has gone overseas with a fighter group. He was formerly at Patterson field, Ohio.

Now among those serving overseas is Captain William Vance, of Richmond. He was previously assigned to Fort Harrison, Indiana.

Word has been received that Major John L. Sharp, of Crawfordsville, has been transferred from Fort Knox, Kentucky, to a New York A.P.O. address.

"This is to be a Regional Station Hospital comparable in the Air Force to a General Hospital with the Infantry," writes Major Carl J. Rudolph, of South Bend, is who is stationed at Buckley Field. "We have over a thousand beds and I am the only oculist, so consequently have no relief for time off. Am continuing to do considerable eye surgery. Quite edified to have been selected as one of four oculists in the Air Force to do research work with penicillin. The other three men, Berens, Thygeson and Allen are the best. Don't know how I was included in such fast company."

We quote from a V-mail letter received from Captain James B. Warringer, of Indianapolis (incidentally, Captain Warringer has just recently received his captaincy): "Your 'MedSoc' letter of January reached me yesterday, and today the one for December came. Thank you very much for this entertaining feature. This tropical scenery is fancy enough but too much on the damp side for my liking. Canned rations are good, movies are frequent, news via short-wave up-to-date, and news via print several days old."

ERRATUM

THE JOURNAL is grateful to Captain Samuel S. Caplin, of Indianapolis, for correcting us with reference to our note in the March issue about his being in Tunisia. The information given us merely said Captain Caplin. We appreciate the humor in Captain Caplin's letter and quote in part therefrom: "Searching my cloudy memory, I find the only relation I can make to the word 'Tunisia' is with a species of fish, and even the War Department tells me I am somewhere in New Guinea. The man who was one day ahead of the famous allergist in Tunisia was probably my brother, Dr. Irvin Caplin, who has been in that theatre for two years. He is the hero—not I. If you do not believe I am here, ask Hugh Thatcher whom I saw on his way to a singing lesson, or ask Aaron Arnold whom I saw taking a shower bath the other day, or ask Fred Malott whom I saw supervising a construction crew. Milton Omstead is also hitchhiking distance away, and Nick Hatfield is said to be prowling around in this vicinity. As for yours truly, I am not vying with McArthur for top honors, but am growing some peachy callouses. . . ."

We have learned that Lieutenant James M. Davis, of Indianapolis, is stationed at Charleston, South Carolina, having been transferred there from Carlisle Barracks.

Now on duty at the naval hospital in Norman, Oklahoma, is Lieutenant K. L. Dickens, of Martinsville. Lieutenant Dickens just recently entered the Navy and reported to the assignment in Norman on April ninth.

Word has reached THE JOURNAL office that Major Gordon H. Haggard, of Columbus, who is serving as a medical officer with the Army Air Forces in England, with a heavy bomber group, has been awarded a medal in connection with his participation in several bomber flights over Nazi-occupied Europe.

Together with his family, Lieutenant Commander Keith E. Shelby, of South Bend, spent a short leave in Yosemite on a skiing expedition. Commander Shelby is reported to have been successful in managing the skis, but met his downfall in the dining room where he slipped with a tray.

As head of a modern, one-hundred-bed hospital, Major Milton W. Erdel, of Frankfort, has seen it grow from two field tents in an English meadow to a four-story, fully-equipped field hospital. Major Erdel has traveled throughout the British Isles while on duty as flight surgeon, and has managed to take a post-graduate course at the University of London. He is now the station surgeon of one of the largest Air Service Command installations in England, according to a news release by an Air Service Command Station in England.

THE JOURNAL office is in receipt of a letter from Captain George W. Herrold, of Lafayette, who states that he is a flight surgeon with the North African Wing of the Air Transport Command, having left the United States in January. He reports that conditions in general are good, and that he enjoys his work very much. He says he enjoys THE JOURNAL from a professional standpoint, as well as the news items concerning fellow-medicos in the service, and expresses appreciation for the "Med-Soc" letters.

Proof that he has only recently arrived in England, says Captain Robert Berke, of South Bend, is the fact that the monetary system is still very confusing. "When it comes to paying for things, I still have to ask twice, and then end up by saying, 'Will this take care of it?' and hand the lady a sum of money." He reports that he had a very nice trip going over, and now that he is there he is playing "country doctor" again, "dispensing pills and castor oil—taking care of hoof and mouth disease. Am taking in the sights and also trying to learn the English language."

Captain Sheldon C. Sommers, of Chicago, and formerly of Indianapolis, has been awarded the Silver Star for heroism in action in Italy. The citation accompanying the award read "Under heavy enemy shell fire, Captain Sommers left his position of safety to care for several men who were wounded by an enemy burst. During this period Captain Sommers was under heavy artillery fire. After the wounded were treated and evacuated, he found that several unseasoned troops were becoming panic stricken. He calmed them and got them to return to their positions. Captain Sommers' action reflects great credit on the medical service."

In a recent letter from Major Kenneth B. Fisher, of South Bend, he says: "I have been very pleased to receive your V-mail, and especially THE JOURNAL of the Indiana State Medical Association. As I have done considerable traveling since leaving South Bend, I am surprised that it still follows me.

"Just a year ago I was transferred from Alaska, after having been there for eighteen months, to the Office of the Coordinator of Inter-American Affairs, Washington, D.C. I was then sent to Peru, South America. I am now stationed in Lima, at the main office. Lima is a beautiful city, and a wonderful place to live. Since coming to Peru, I received my majority last August 7, 1943. All of our doctors are in the Army, as are the sanitary engineers. Major General George C. Dunham, M.C., was through here last week, as he heads our work in Latin America. He is a wonderful man to work for and with."

A communication received from the Headquarters of the European Theater of Operations, United States Army, states that a Medical Corps repair depot in England—the only one of its kind in the United States Army—is bustling with pre-invasion activity: installing, repairing, and servicing all electro-medical equipment that will be used in healing combat casualties. This depot gives twenty-four hour service. If the machine can not be repaired in that time, a truck brings a new machine to the hospital or dispensary and returns the damaged one to the depot for complete overhauling; air priority is given to these technicians on rush jobs. Since the unit has been in operation, servicemen have traveled 160,000 miles and now average more than 12,000 miles a month in their thirteen vehicles. More than 55,000 work orders have been completed. One morning's list included repair of litters, dental chairs, cystoscopes, anesthesia equipment, x-ray machines, gas generators, blood pressure sphygmomanometers, syringes, forceps and regular operating equipment. Only five per cent of all medical equipment sent to this installation for repair has had to be salvaged; only three out of more than 1,000 x-ray machines had to be junked. A Hoosier Warrant Officer, Claude G. Todd, of Huntington, is chief of the X-ray Maintenance and Repair Department at this depot.

THE JOURNAL office is in receipt of a letter from Captain Charles E. Holland, of Bloomington, who recently transferred from Lincoln, Nebraska, to Lowry Field, Denver, Colorado, from which we quote in part: "I've had some fine experiences in this man's army, even though I have been associated with 'dispensary services' for twenty-two months. I have had the experience of being with some of the finest men in their field. Those of us having been stationed here in Lincoln have been quite fortunate in having fine men for chiefs of services. All of us younger men have learned a lot, and the experience has been quite valuable.

"We have had our share of Indiana boys here—at one time there was William Clark, of South Bend, in EENT; Harry Pandolfo, of Indianapolis, medical inspector; Eugene DeGrazia, of Valparaiso, in surgery; Carl Rudolph, of South Bend, in EENT (now somewhere else); Ralph Wilmore, of Indianapolis, in dispensaries; Orien Patch, formerly of Fort Wayne, now from Duluth, Minnesota, in EENT (he classes himself as a Hoosier for self-preservation); and myself—at present chief of dispensaries but scheduled to move on to Denver on May first. All in all, it has been a great hospital and a great experience.

"As I stated before, the Army experience has been invaluable, and it is unfortunate that all couldn't have taken advantage of it. It's really worth while."

The LaPorte County Medical Society has favored us with a copy of their Bulletin, from which we quote a letter written by Captain John R. Mathew, of Knox:

"We are up here maneuvering in the snow with the best winter equipment in the world. However there isn't much snow, and there is a constant conflict between the prayers of the big shots and those of the men praying for either snow or no snow. So far the men have won.

"At present the men are busy sweeping sleet from the roof, so it won't come down on top of us. Leave it to the medics to secure a roof. Everyone else is as wet as a rat and slept in sleeping bags with rain in their faces last night. Put out snares for rabbits yesterday with the colonel who shot two with a pistol. With all this training you can form your own opinion as to where we will go some day. We have formed ours and will compare notes later.

"To all those boys who have either wooden or canvas roofs over their heads in evac, general or station hospitals, I must say this, that they had better bow their heads to those who are plodding ahead of them by foot, putting up with inconveniences a million-fold worse, including two or three years waiting and training before their real work begins. Those are the real men who can be proud of their physical condition, and that is something to be proud of—take it from me.

"Regards to all and will be glad to be with you again some day."

It is the opinion of Major Daniel Stiver, of South Bend, that any of the men suffering from coronaries should come to Persia, where he is stationed. He said that he recently did an appendectomy, and added that he was glad he still wore shoes that tied, for that is what made it possible for him to remember how to do the knots.

From Captain Fred G. Perry, of Plymouth, comes a very interesting letter, and one which contains a pointer or two for the ones of us at home. (For this letter also we thank the *St. Joseph County Service Bulletin*, from which it is extracted.)

"The weather is beginning to get hot and will reach a peak in a month or so. About May the monsoons start and we'll have a hot, rainy season that lasts about five or six months. Even during the very worst rains the temperature may be 130 degrees. Mud and mold cover clothes and equipment. Have had lots of fun buying some Indian jewelry and souvenirs of the area. Some of it is rather pretty but their wearing qualities will certainly be low. Bought a couple of 'emeralds' and a large 'ruby' the other day. They are very pretty but believe it would be better not to have them appraised. We took some pictures today. They are most typical of the people in a small Indian village. The native doctor was with us and helped us to get the natives to pose. Usually the women are inclined to cover their faces and run away so you rarely see much of them.

"The other day I had an opportunity to have a cup of American coffee and sugar and see some American eggs and a frigidaire. In this short time I had forgotten how fine and white sugar is; how swell the aroma of coffee is; how large eggs can be and what a wonderful sight an icebox stuffed with food is, and what ice cubes felt like. The United States is a dreamland and the joy, pleasure and satisfaction we'll get in returning to appreciate its many, many advantages in a new way will be unlimited. Just the thought of being able to walk into a hamburger joint and have a clean sandwich and a glass of milk brings a smile to my face; mosquitoes that are a nuisance and not a menace to your health and life; clean sheets, clean vegetables; cold, clean milk; paved streets; hot water; a comfortable \$900.00 automobile; a city with no odor; a chocolate sundae; a good movie with cushioned seats—all those things we have grown to expect and forgot to acknowledge. Believe me, I'm not kicking now about how rough we have it or how easy the civilians at home have it. Personally, I'm getting along fine, but we Americans must know and admit to ourselves what a hell of a swell place we live in—and keep it that way. Guess I'm a little selfish, but the very thoughts of trying to make India like the USA is discouraging, and I'd fear the loss of some of the things we call essential. If we could keep everything we have and help the entire world, it would be O.K., but I wonder if you can have your cake and eat it, too.

News Notes

Dr. H. E. Parker has opened offices in Brookston for the practice of medicine. Dr. Parker was previously at Lafayette with the Aluminum Company of America.

Dr. Metodi Velkoff has recently opened an office in Fort Wayne for the practice of radiology. He served sixteen months as a major in the United States Army, returning in 1943.

Dr. Richard K. Parrish, of Decatur, recently opened offices there for the practice of medicine. After two and one-half years' service with the Navy, Dr. Parrish was given a medical discharge.

Colonel Claude D. Holmes retired from active duty in the Army Medical Corps, as of May first, going on a five months' terminal leave. He was stationed at the Holabird Signal Depot, Baltimore, Maryland. His present address is Frankfort.

Dr. Harold Vonachen, Medical Director, Caterpillar Tractor Corporation of Peoria, Illinois, became the sixth recipient of the William S. Knudsen Award. This award is made annually by the American Association of Industrial Physicians and Surgeons to the individual who has made the most outstanding contribution to Industrial Medicine.

Dr. Vonachen received the award for his work on the rehabilitation of the handicapped veteran. This subject was discussed by Dr. Vonachen before the Second Annual Industrial Health Conference of the Indiana State Medical Association.

AMERICAN CONGRESS OF PHYSICAL THERAPY

The American Congress of Physical Therapy will hold its twenty-third annual scientific and clinical session September 6, 7, 8 and 9, inclusive, at the Hotel Statler, Cleveland, Ohio. Rehabilitation is in the spotlight today—Physical Therapy plays an important part in this work. The annual instruction course will be held from 8:00 to 10:30 A.M., and from 1:00 to 2:00 P.M. during the days of September 6, 7 and 8. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. All of these sessions will be open to the members of the regular medical profession and their qualified aids. For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago 2, Illinois.

INFORMATION DESIRED CONCERNING BOONE COUNTY PIONEER PHYSICIANS

According to the *Lebanon Reporter*, the Witham Hospital, at Lebanon, is compiling biographies of all physicians having practiced in Boone County from the pioneer days to the present time, thus hoping to have a complete record of the medical profession for its library. Anyone having information concerning any of the pioneer physicians of Boone County, or interesting facts pertaining to the practice of medicine in the early days, is asked to communicate with the above hospital.

Certificates for volunteer services for a period of at least six months were awarded on April twenty-seventh to nine Evansville physicians who assisted in physical examinations of draft registrants from the Evansville district. The certificates state that their services have enabled the War Department to utilize medical officers in combat zones or other theatres of war. Those receiving the certificates were: Drs. Minor W. Miller, W. W. Eichelberger, H. M. Kauffman, W. G. French, B. L. Cody, S. R. Laubscher, A. J. Niedermayer, A. J. Murphy and Marcus Ravdin.

INDIANA ASSOCIATION OF THE HISTORY OF MEDICINE

The members of the Indiana Association of the History of Medicine were entertained at the home of Dr. and Mrs. Edgar F. Kiser, of Indianapolis, on May tenth. Doctor Kiser, in his inimitable manner, gave a graphic description of the history of the famous Guy Hospital in London, founded by Sir Thomas Guy in 1724, and described the almost continuous two-year German bombardment in 1940 and 1941 (which, however, failed to destroy the hospital) and the work involved in maintaining the hospital services.

The information concerning the Guy Hospital had been supplied by Captain B. D. Rosenak, of Indianapolis, who is with the Medical Corps in England.

Doctor Kiser's talk was further illustrated with lantern slides, which not only depicted the devastation caused by the bombing but also the courage of the people in continuing the preservation of the hospital. This epoch-making era is, indeed, "History in the Making," which was the title of his discussion.

Another interesting phase of history was covered by the illustration of slides showing the development of the insignia of the United States Medical Corps, beginning with the first emblem, "Status of Aesculapius," and the adoption of five different emblems, including the present insignia—the "Caduceus."

Fae Spurlock, M.D., has accepted a residency at the Cleveland Clinic, in Cleveland, Ohio.

W. W. Gipe, M.D., formerly of Kokomo but recently living in Tuscon, Arizona, has announced his intention of re-locating in Kokomo.

Posey County commissioners appointed Dr. John W. Herr as health commissioner to fill the unexpired term of Dr. William E. Jenkinson, who resigned to enter the armed forces.

Dr. Edward J. Swets, of Hammond, and Miss Eileen Newby, of Indianapolis, were married on April twenty-ninth at the Delta Delta Delta sorority house on the Butler University campus at Indianapolis. Dr. and Mrs. Swets will live in Seattle, Washington, where Doctor Swets will intern at a Marine hospital.

Dr. and Mrs. Howard A. Bosler, of New Paris, sailed from Philadelphia the latter part of April for Nigeria, where they will take up work as medical missionaries. Doctor Bosler will be in charge of an area covering one-hundred-fifty miles which includes two general hospitals, several first aid stations, and a large leper colony. In addition to having received his M.D. degree from the Indiana University School of Medicine, Doctor Bosler is an ordained minister in the Church of the Brethren. This is the third trip to Africa for Doctor and Mrs. Bosler. They expect to return in four years.

INDIANA UNIVERSITY NEWS NOTES

Recognized otolaryngologists from sixteen different states attended the Clin'co-Anatomical Postgraduate Course in Otorhinolaryngology conducted recently by the Indiana University School of Medicine. The clinic was devoted to co-related subjects of otolaryngology, important discussions, and surgical and dry clinics. This intensive course was organized twenty-five years ago by the late Dr. John F. Barnhill, former head of the Indiana University Department of Otorhinolaryngology, and is given annually in April. It is the only postgraduate course now being given by the Indiana University Medical School during the period of national emergency. It was conducted by Dean W. D. Gatch, of the medical school; Dr. Thurman B. Rice, chairman of the Ophthalmology, Bacteriology and Public Health Department; Dr. Clyde Culbertson, chairman of the Clinical Pathology Department; Dr. Raymond Beeler, chairman of the Roentgenology Department; Dr. Lester Smith, chairman of the Radiology Department; Dr. C. H. McCaskey, chairman of the Otolaryngology Department; Dr. Edwin N. Kime, chairman of the

Anatomy Department, and Dr. K. G. Wakim, of the Physiology Department.

At the recent commencement of Indiana University, the following 114 students received the Doctor of Medicine degree:

Marion F. Arnold, Jr., New Palestine; Charles Baran, Gary; Bruce S. Barnes, Evansville; Maurice J. Barry, Indianapolis; Norman E. Beaver, Otterbein; Robert O. Bethea, Madison; Elmer R. Billings, Washington; Angelo P. Bonaventura, East Chicago; Robert W. Boswell, Evansville; Robert L. Brown, Evansville; Harry J. Bugel, Ansonia, Connecticut; Frank W. Bussard, South Bend; Robert N. Chatten, Union City; Kenneth L. Cline, Bremen; William L. Colip, South Bend; Urban J. Collignon, Columbus; Charles W. Cure, Martinsville; Margaret M. Davis, Clarks Hill; Richard M. Davis, Marion; Jack E. Deming, Indianapolis; Edmunds G. Dimond, Terre Haute; Robert D. Dodd, South Bend; Leland F. Downard, Liberty; Robert J. Duffner, Fort Wayne; Joseph P. Duffy, Jr., Terre Haute; Merrill T. Eaton, Jr., Bloomington; Isidore S. Edelman, Brooklyn, New York; Otto T. Englehart, Jr., Brazil; Ira L. Faith, Evansville; John J. Farris, Washington; James S. Fitzpatrick, Bloomfield; Bernard E. Flaherty, Indianapolis; Donald T. Foxworthy, Waldron; Robert L. Gammieri, Indianapolis; Edwin E. Gregg, Indianapolis; Charles F. Gregory, Fremont; William V. Hare, Evansville; Norman B. Hasler, Huntingburg; Charles R. Headlee, Shelbyville; Mrs. Herman S. Hepner, Bloomington; Claude D. Holmes, Jr., Lebanon; Preston S. Houk, Portland; Harold B. Houser, North Liberty; Fred D. Houston, Franklin; Glenn W. Irwin, Jr., Roachdale; Robert P. Jay, Kokomo; Robert E. Jenkins, Noblesville; Chester R. Johnson, Jr., Indianapolis; Grant C. Johnson, Noblesville; David M. Jones, Indianapolis; Rex M. Joseph, Indianapolis; Walter T. Jurgensen, Fort Wayne; Clement E. Kelley, Indianapolis; Frederick L. Kiechle, Evansville; Robert Kimbrough, Logansport; Norris J. Knoy, Paragon; Robert O. Lancet, Indianapolis; Sanford H. Lawrence, Kokomo; Henry S. Lebeda, Gary; Ray Lindenschmidt, Evansville; Robert P. Lloyd, Fort Wayne; Harvey D. Lovett, Zionsville; Harry A. Ludwick, South Bend; Hugh B. McAdams, Boswell; Michael F. McGrath, Indianapolis; Paul E. McGuff, West Lafayette; Joseph McKinley, Delphi; Frederick O. Mackel, Clinton; Maurice M. Manalan, Gary; Glenn L. Marshall, Bloomington; Harold R. Martin, West Lafayette; Merritt C. Mauzy, New Paris; Richard C. Minczewski, South Bend; Raymond Morphew, Williamsport; Hascall H. Muntz, Sylvania, Ohio; Royal G. Neher, North Manchester; Harry W. O'Dell, Farmersburg; Martin J. O'Neill, Indianapolis; Sam E. Pobanz, Wakarusa; Ronald D. Price, Mount Vernon; Mrs. Carolyn Mann Rawlins, Hammond; John J. Reinhard, Jr., Washington, D. C.; Richard Reynolds, Bloomington; John W. Ripley, Milford; Harry Sacks, East Chicago; Arnold R. Sanders, New York City; William J. Schechter, Indianapolis; Robert J. Schmolli, Fort Wayne; Dwight W. Schuster, Indianapolis; Earl W. Sidebottom, Rushville; Paul Siebenmorgan, Terre Haute; Penn G. Skillern III, South Bend; Marsh H. Smith, West Lafayette; Richard B. Smith, New Haven; Roger C. Smith, New Haven; William O. Starks, Indianapolis; Edward J. Swets, Hammond; Alfred T. Symmes, Indianapolis; Harold R. Tharp, Trafalgar; Frank M. Thornburg, Richmond; Joseph Tuchman, Indianapolis; Robert L. Tucker, Fountaintown; John C. Vanatta III, Brookston; Wallace R. Van Den Bosch, Mooresville; Myron J. Van Dorn, Indianapolis; George K. Washington, Gary; George S. Westfall, Goshen; Donald C. Wharton, Fort Wayne; Clifford A. Wiethoff, Seymour; Max B. Wills, Anderson; Ben Wilson, Jr., Bloomington; Paul E. Wisenbaugh, North Liberty; Robert L. Witham, Indianapolis; and Louis A. Zuckerman, Paterson, New Jersey.

Deaths

DIED IN MILITARY SERVICE



Colonel Frank Bolles Wakeman

Colonel Frank Bolles Wakeman, M.C., United States Army, Washington, D.C., died March 17, 1944, while attending an officers' conference at Fort Monmouth, New Jersey. He was the Chief of the Training Division of the Office of the Surgeon General. He had maintained his home at Valparaíso.

He was born May 15, 1896, at Sidney, New York, and graduated from the Indiana University School of Medicine in 1926; from the Army Medical School in 1929, advanced course in 1936; graduated from the Medical Field School, Carlisle Barracks, in 1929, and advanced course in 1938. In 1916 he received a degree in pharmaceutical chemistry, and served as an instructor in biochemistry at the Army Field Service School in 1932-1936, and instructor in sanitation at the Medical Field Service School in 1937-1939. In 1933 he received the degree of Master of Arts, and the degree of Doctor of Philosophy in 1935 from the Catholic University of America, and the degree of Doctor of Public Health in 1937 from Johns Hopkins University School of Public Health. He graduated from the Command and General Staff School, Fort Leavenworth, Kansas, in 1940.

During World War I Colonel Wakeman served as a first lieutenant in the Officers Reserve Corps from August, 1917, to May 31, 1919, being overseas with the 369th United States Infantry (old fifteenth New York Infantry), and was on active duty with the Medical Reserve Corps from August 1, 1926, to August 21, 1927, during

which time he completed an internship at Walter Reed General Hospital. He practiced medicine in Indiana from August, 1927, to May, 1928. He was appointed a first lieutenant in the Medical Corps of the regular Army on March 23, 1928, and promoted to a captain in June, 1928; a major in June, 1937; temporary lieutenant colonel in February, 1942, and temporary colonel in September, 1942.

In 1938 Colonel Wakeman was awarded the Sir Henry Wellcome prize by the Association of Military Surgeons of the United States for his essay on "A Specific Somatic Polysaccharide as the Essential Immunizing Antigen of the Typhoid Bacillus."

He was a member of the Association of Military Surgeons of the United States, and the Society of American Bacteriologists, and was a Fellow of the American College of Physicians.



Captain John Elliott Carter

Captain John Elliott Carter, M.R.C., United States Army, died in military service in the Southwest Pacific on July 22, 1943. He was thirty-one years of age. Before entering service he was in practice at Richmond.

Captain Carter was born in Wawa, Pennsylvania; received his M.D. degree from the Western Reserve University Medical School, Ohio, in June, 1938; interned at the Methodist Hospital, Indianapolis, in 1938-1939; was a resident in pathology at the Ball Memorial Hospital, Muncie, in 1939-1940 and at the Methodist Hospital, Indianapolis, in 1940-1941.

On January 14, 1941, he was commissioned a first lieutenant in the Medical Reserve Corps. He was first stationed at Camp Shelby, Mississippi, later at Indiantown Gap, Pennsylvania, with the 145th Infantry, and was sent to the west coast in 1942. He received his captaincy shortly before embarking for the South Pacific. He was in New Zealand and later in the Fiji Islands. As late as June, 1943, he was on Guadalcanal, where he served as battalion surgeon to the 1st Battalion, 145th Infantry.

He was reported killed in action, but no further details are known. He was posthumously awarded the Purple Heart.

Angus C. McDonald, M.D., of Warsaw, died on April twenty-third following a six weeks' illness. He was seventy-nine years of age. He graduated from the University of Pennsylvania School of

Medicine, Philadelphia, in 1892, and had practiced at Warsaw about fifty years, retiring a few years ago. He was the founder of the first hospital in Kosciusko County, and later built and equipped the McDonald Hospital at Warsaw.

Doctor McDonald was a past president of the Indiana State Medical Association, having served as its president in 1930.

In addition, he served the Indiana State Medical Association in the following capacities: Councilor, Thirteenth District, 1911-1917; president-elect, 1929; Committee on Budget, 1929-1930 and 1931, and Executive Committee, 1930. He was a member of the American College of Surgeons, a member of the Kosciusko County Medical Society, was an honorary member of the Indiana State Medical Association, and was a member of the American Medical Association.

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Harley L. Cunningham, M.D., of Ashley, died April eleventh at the age of eighty-two. He had been ill for a number of years. Dr. Cunningham graduated from the Michigan College of Medicine and Surgery, at Detroit, in 1894.

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Charles M. Eisenbeiss, M.D., of New Paris, died May third at the age of seventy-three. He was a graduate of the Kentucky School of Medicine, at Louisville, in 1892. Dr. Eisenbeiss retired from active practice several years ago.

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J. F. Bowen, M.D., of Rushville, died April twenty-first at the age of seventy-three after practicing forty-six years. He was a graduate of the Medical College of Indiana, at Indianapolis, in 1897. Dr. Bowen was a member of the Rush County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Homer Woolery, M.D., of Bloomington, died April twenty-second at the age of seventy-two. He was a graduate of the State College of Physicians and Surgeons, in Indianapolis, with the class of 1907.

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Charles E. Rariden, M.D., of Bedford, died April twenty-ninth in Dalton, Georgia, while en route to his home in Bedford. He was eighty-eight years of age. Dr. Rariden was a graduate of the Kentucky School of Medicine, in Louisville, in 1880. He had retired from active practice.

* * *

George C. Smith, M.D., of Poseyville, died May second at an Evansville hospital. He was eighty years of age. Dr. Smith was a graduate of the Jefferson Medical College, in Philadelphia, in 1891. He had been in practice for fifty-five years. Dr. Smith was a member of the Posey County Medical Society, the Indiana State Medical Association and the American Medical Association.

* * *

Albert C. Holley, M.D., of Attica, died April twenty-sixth. He was seventy-one years of age. Dr. Holley was a graduate of the Hahnemann Medical College and Hospital, in Chicago, in 1896, and had been practicing in Attica for nearly fifty years. Dr. Holley was especially interested in radiology and roentgenology. He was a member of the Fountain-Warren County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

John T. McFarlin, M.D., of Williams, died April eighteenth at the age of seventy-six. He was a graduate of the University of Louisville School of Medicine in 1894, and had practiced in Williams since that time with the exception of the time he served as captain in the Army Medical Corps during World War I. Dr. McFarlin was a member of the Lawrence County Medical Society, and had at one time served as its president. He was an honorary member of the Indiana State Medical Association and was a member of the American Medical Association.

* * *

Harmon L. Stanton, M.D., of Evansville, died suddenly on April twenty-third. He was fifty years of age. Dr. Stanton graduated from the State University of Iowa College of Medicine, Iowa City, in 1920, and limited his practice to otorhinolaryngology. He was certified by the American Board of Otolaryngology and was a member of the American Academy of Ophthalmology and Otolaryngology. He was a member and past president of the Vanderburgh County Medical Society, and had served as president of the city health board. Dr. Stanton was also a member of the Indiana State Medical Association and was a Fellow of the American Medical Association.

POST-WAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of June, 1919)

In the scientific section we find four articles: "Bacteriology and Pathology of the Epidemic of Influenza," by Virgil H. Moon, Indianapolis; "Medical Treatment of Duodenal Ulcer," by Frank W. Foxworthy, Indianapolis; "Focal Infections," by C. C. Cotton, Elwood; and "Headache as a Symptom," by J. G. Jones, Vincennes.

* * *

Editorially, there were but two items, yet each was quite apropos to the times; the lead editorial having to do with roentgenology, which the editor believed should be a specialty in itself. He decried the fact that too many medical men bought an x-ray outfit, without much conception of what the pictures showed after they had been developed.

The second editorial, prophetic in character, is of such interest that it is reproduced in our current editorial pages. At least two men in Indiana, Editor Bulson, and Maynard Austin of Anderson, had the foresight to predict just what is happening within the profession as of today. We recall many of the writings of the latter, in which he urged a "preparedness program" which, had it been started twenty-five years ago, would have come in handy today.

* * *

Thirty-one nurses were graduated from the Indianapolis City Hospital; forty-three from Methodist.

* * *

One hundred forty-five applicants took the annual examination given by the State Nurses' Board.

* * *

Lafayette hospitals had opened a campaign against fee-splitting. Every physician practicing in those institutions was required to sign a "I-wouldn't-think-of-doing-such-a-thing" agreement.

* * *

Doctor Bulson made quite a play on an item from the *Indianapolis News*, of May twelfth, "Ben Winans, of Pleasant Mills, can see after being totally blind for eight or nine years. 'Recently his head came in contact with a chair, inflicting a deep scalp wound. The tincture of lead which the physician used on the wound cut the double cataract which had blinded Winans and his sight, it is said, is practically restored.'"

Dr. Bulson properly cites the fact that a medieval treatment for cataract consisted in bashing the head of the patient with a mallet, which occasionally would rupture the lens capsule, permitting the lens to escape. (One drawback to this form of treatment, so the literature says, is the fact that too many of such patients got no more than a fracture of the skull or a concussion as a result of the application of this force.)

Post-War planning, then as now, was a universal topic.

* * *

The editor commented on some post-war problems, having a bit to say about the proposal for a six-hour day for labor, with payment on a ten-hour-day basis, plus an increase in the hourly wage.

* * *

There was some comment on how former patients should address returning medical officers. Should they revert to the usual greeting, "Hello, Doc"—or should they say, "Good Morning, Captain," "Colonel," or whatever title the man might have had in service? The editor opined that the term "Doc" would again become common usage.

* * *

The war had taught the public one lesson, the fact that typhoid fever is unnecessary and can well be controlled.

* * *

Dr. Maynard Austin, Anderson, evidently was quite concerned over the fact that he had some money in his possession that belonged to someone else — he was not quite certain to whom, and wanted to pay it over to the proper person. It seems that about a year previously there had been organized a "Physicians' Protective Association," the stock being sold to physicians, but the war had put a crimp in the plans, hence the dissolution. It was discovered that one physician had not received his money and Doctor Austin was sending out a call for any other who had been overlooked to make themselves known.

* * *

All Selective Service Boards had been discontinued, and the War Department, together with state governors, were busy sending letters of appreciation to all who had worked in that capacity.

* * *

An Evansville physician, evidently still disgruntled over some of the inconveniences experienced as a member of the Medical Corps, wrote quite a letter about it to THE JOURNAL. Said he was writing a book on his personal experiences, said volume to be entitled, "The Confessions of a Cootie Catcher." A few of the proposed chapter titles are: "Why politics did not enter our M.R.C. It didn't have to, it was there all the time." "Why I stayed home and got a higher rank than the fellows who first volunteered." "Why I am going to place my boy in the *Regular Army Medical Corps*. For answer, see the casualty list." "How performing Squads East and Platoons West helped us to become good surgeons."

Society Reports

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

April 16, 1944.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Luncheon meeting: Group representing pathologists and radiologists: C. G. Culbertson, M.D., Indianapolis; Lall G. Montgomery, M.D., Muncie, and Frank Forry, M.D., Indianapolis, pathologists; Wemple Dodds, M.D., Crawfordsville, and E. B. Jewell, M.D., Logansport, pathologists and radiologists; Bruce W. Stocking, M.D., Muncie, Radiologist.

Membership Report

Number of members April 15, 1944.....	2,966
Number of members April 15, 1943.....	2,861
Gain over last year.....	105
Number of members December 31, 1943.....	3,344

Expansion of Office

Establishment of a new office of THE JOURNAL at 1017 Hume-Mansur Building, Indianapolis.

Application made to Procurement and Assignment Service for additional stenographic help; report received from Washington that this has been approved.

The committee approved the purchase of office supplies and payment for these and also several other accounts separately by THE JOURNAL office and the headquarters' office. Previously some of the supplies used by THE JOURNAL office and charges for the maintenance of typewriters, et cetera, were paid for by the headquarters' office.

The statement of receipts and expenditures and report on the budget for February and March for THE JOURNAL were approved.

1944 Annual Session, Indianapolis, October 3, 4 and 5, 1944

Arrangements made with Dr. C. E. Cox, treasurer, and Karl Friedrichs, building manager, to use the Murat Temple for the annual session.

Commercial exhibit:

Seventy spaces to be sold.

Forty-three spaces sold to date.

Scientific program:

Word received from Office of the Air Surgeon that the Air Forces will cooperate in holding the meeting.

Speakers who have accepted places on the program are: Newell C. Gilbert, M.D., Chicago; Chester S. Keefer, M.D., Boston, who has charge of the distribution of penicillin; Colonel Paul Holbrook, M.C., Army Air Forces, Washington, D.C.

Legislative, Legal and Social Security Matters National

The United Public Health League has established an office at 410 Hill Building, in Washington, D.C., under the direction of Ben Read, director of the California Public Health League. Request to be made of Mr. Read that the members of the Executive Committee and of the state Legislative Committee be placed upon the mailing list of the league.

Status of Wagner-Murray-Dingell Bill

Bill still in committee.

Letter in "Voice of the People" in *South Bend Tribune*, favoring the bill, brought to the attention of the committee.

Correspondence with Dr. Fred R. Reed, chairman of the Legislative Committee of the Michigan State Medical Society, brought to the attention of the committee.

The following statement, made by Father Alphonse M. Schwitalla, on the Wagner-Murray-Dingell Bill, which appeared in the February 25, 1944, bulletin of the Council on Public Relations of the American Medical Association, was brought to the attention of the committee:

"The partnership between the voluntary agencies and government agencies in health care must be progressively emphasized, particularly through legislative enactments, provided, however, that that partnership be viewed as a true partnership and not merely as a cooperative effort in which the government is dominant.

"The principle of prepayment against the costs of eventual illness must be accepted and plans developed to encourage each individual through such prepayment to make preparation against the hazards of illness. Prepayment insurance systems on a voluntary basis providing income for the various contingencies arising out of illness cannot but merit the support of every thinking person. It would not be contrary to Catholic thinking to encourage a government mandate requiring wage earners to provide for themselves and their dependents through some form of insurance, and such provision might even be made a necessary condition for employment. But the method of that insurance should still remain the free choice of the wage earner who makes the prepayment. The prepayment funds belong to the wage earner, and he should be allowed the determination of what he desires to purchase with his prepayment. It is dangerous in the health area to treat prepayment against the hazards of illness as a tax, no matter what may be thought of a similar procedure regarding prepayment against the hazards of unemployment and old age. If regulation of voluntary agencies accepting such prepayment is required to protect the nation, such regulation, if effective through

wise laws, cannot but merit the support of our citizens. The responsibilities of the physician must by all means be safeguarded as one of the essential basic elements of human society. Those responsibilities must be conceived as having an ethical and not merely a scientific or an economic implication. Prepayment plans for medical care, if carefully planned and so devised as to make it possible for the physician to carry out his ethical and his other professional responsibilities, should again be supported and encouraged.

"The Catholic group of citizens should give hearty support to the Federal Government in its efforts to extend both governmental and voluntary hospital and medical care systems into areas in which needs are recognized. Inducements should be offered to physicians to seek less favorable areas for their practice, but these inducements should in no way limit the liberties of medical practice and the ethical responsibilities of the physician.

"In the projected extension and redistribution of hospitals, health facilities, and health-caring personnel, the best and most deeply appreciated features of existing systems should by all means be retained; such features as the personal relationship between patients and physicians, the freedom of the patient to choose his physician and his hospital, the rights and responsibilities of private health-caring agencies, features which are found to be fully consonant with Catholic thinking, while alternatives to these features have in many cases merited the fully justified opposition of those who are entrusted with the health care of our people."

Hearing in Washington upon appropriations for the extension of the Emergency Maternity and Infant Care Program scheduled for April 27 and 28. This information has been passed on to the various county medical societies.

Resolution of the Chicago Medical Society against the Children's Bureau brought to the attention of the committee. The committee approved the publication of these resolutions in *THE JOURNAL* of the Indiana State Medical Association.

Resolution passed by the Council of the Nebraska State Medical Association, asking for direct payment of "EMIC" funds to the families of servicemen rather than to the physician, brought to the attention of the committee.

H.R. 4371, placing the administration of some of the industrial health laws in the hands of the Department of Labor discussed by the committee. Word received that Representative A. L. Miller, of Nebraska, who is on the committee to which the bill has been referred, "is hopeful that he may be able to reach some agreement with the sponsors of the bill whereby all reference in it to health may be deleted."

Statement by Governor John W. Bricker, of Ohio, against socialized medicine, as reprinted in the April issue of *THE JOURNAL* of the Indiana

State Medical Association, approved by the committee.

Local

Special legislative session developed no legislation directly affecting the medical profession.

Clerk's birth certificate bill and a letter from Dr. John E. Yarling, city health officer, Peru, discussed by the committee.

Public Relations

Discussion held in regard to separate medical economic and legislative organizations. Letter from the *United Public Health League*, the new bulletin of the Association of American Physicians and Surgeons, Inc., Lake County, and public opinion material from the National Physicians and Surgeons group, all brought to the attention of the committee. The committee reaffirmed its position that the Indiana State Medical Association does not officially recognize any of these groups.

Report received that the Bartholomew County Medical Society had voted to join the "Association of American Physicians and Surgeons."

The following letter received from Dr. G. Lombard Kelly, secretary of the Council on Medical Service and Public Relations of the American Medical Association, was brought to the attention of the committee:

"I am writing to inform you that I have been instructed by the Council on Medical Service and Public Relations to compliment the Indiana State Medical Association and its officers for the fine piece of work that they have done in behalf of organized medicine. The Council feels that your accomplishments have been outstanding and worthy of signal praise."

The committee expressed its appreciation and particularly approved the work of the Bureau of Publicity and the Secretaries' Conference Committee in setting up the "School for Speakers," which has served as a basis for similar programs in other states, to prepare the physicians to discuss the Wagner-Murray-Dingell Bill.

Committee informed of letter received from Dr. A. M. Mitchell in regard to the presentation of a resolution creating a speakers' bureau as a part of the Public Relations and Medical Service Committee of the American Medical Association. The committee suggested that Dr. Mitchell should first take this up with the Vigo County Medical Society.

Editorial in *California and Western Medicine* entitled, "Unrest Among American Physicians" and editorial in March issue of *Medical Economics* entitled, "More Realism, Please," commenting on A.M.A. public relations, brought to the attention of the committee.

Organization Matters

Suit against a physician in a county of southern Indiana for grand larceny brought to the attention of the committee.

Letter from N. H. Prentiss, M.D., chairman of the Committee on Physical Therapy, in regard to

Limitation Order L-259, brought to the attention of the committee. The committee expressed the hope that Dr. Prentiss would keep it informed concerning the status of the practice of physical therapy under this order which restricts the purchase of new physical therapy equipment.

Correspondence in regard to a physician who lives in Marion County and is applying for membership in Tippecanoe County brought to the attention of the committee. Copy of the By-Laws of the association covering such membership forwarded to the Tippecanoe County Medical Society.

Letter received from Arthur J. Cramp, M.D., who was made an honorary member of the Indiana State Medical Association by action of the House of Delegates at the 1943 meeting, brought to the attention of the committee.

Medical Economics

Expert medical testimony. Work done by the Minnesota State Medical Association, as reported in the April 1 issue of the American Medical Association Journal, and a letter concerning the work there by H. B. Annis, M.D., of Bluffton, Indiana, brought to the attention of the Executive Committee by Dr. Oliphant. The committee referred this material to Albert Stump, attorney for the association.

Correspondence from Dr. C. R. Bird to Dr. Oliphant in regard to mileage fee charges referred to the committee. The committee discussed the question of charges and suggested that local societies appoint committees to investigate these matters in each case where reports have been made that such charges have been excessive.

The Sullivan County hospital situation has been satisfactorily settled, according to a report made by Dr. Oliphant.

Copy of the fee bill adopted by the Hancock County Medical Society, effective April 12, brought to the attention of the committee.

War Medicine

Report made that Dr. C. R. Bird is ill in the hospital and that Dr. John R. Newcomb is acting as state chairman for the Procurement and Assignment Service.

Announcement of the United States Public Health Service that it will pay certain expenses of physicians locating in communities in need of physicians brought to the attention of the committee.

a. Letter received from the Ben Davis Parent-Teacher Association, asking that the United States Public Health Service place a physician in that community. The Executive Committee suggested that this be forwarded to the Indianapolis Medical Society.

b. Release from the *Pathfinder*, a paper with wide circulation among farmers, entitled, "Doctor Shortage Perils Public Health," brought to the attention of the committee.

Letter from Headquarters Army Service Forces announcing openings in the Veterans Administra-

tion for physicians up to sixty-three years of age, on a full-time basis, brought to the attention of the committee.

Suggested resolutions of Major George Dillinger, to be introduced at the next meeting of the House of Delegates of the American Medical Association, brought to the attention of the committee. The committee suggested that copies of these suggested resolutions be made and sent to members of the committee for study so they may be discussed at the May meeting of the Executive Committee.

Suggestion that buttons be given to physicians physically disqualified for service. The Executive Committee felt that this is a matter that should be taken up by the Procurement and Assignment Service.

The Indiana Committee on Procurement and Assignment for Nurses has asked that Thomas Hendricks serve as a member of that committee. The committee approved the acceptance by Mr. Hendricks of that position.

State Board of Health

The typhoid epidemic and complaints of physicians of Miami County brought to the attention of the committee. The committee expressed itself as willing to consider such complaints as may come from physicians of the Miami County Medical Society if exact facts and data are given.

Letter from Dr. Herman Baker in regard to the establishment of a school of public health at the Indiana University School of Medicine brought to the attention of the committee.

Letter from Joseph L. Quinn, Jr., acting director of the Division of Environmental Sanitation of the Indiana State Board of Health, concerning the organization of an Indiana Public Health Association, brought to the attention of the committee.

Socialized Medicine

Questionnaire sent to members of the British Medical Association, dealing with the "government's new health plan," brought to the attention of the committee. Copies of this are to be sent to the members of the Executive Committee.

Group Hospitalization and Voluntary Health Insurance

The Executive Committee met with representatives of the radiologists and pathologists and discussed the proposed Blue Cross hospital insurance plan.

Resolutions passed by various county medical societies, asking that services rendered by radiologists and pathologists be considered as medical services and not technicians' or hospital services, discussed by the committee.

Letter from Dr. Charles N. Combs, appointing Dr. Bruce Stocking, Muncie, and Dr. Wemple Dodds, Crawfordsville, as members of the Blue Cross Committee, received and approved.

Final suggestion of committee is that the Blue Cross organization be set up so as to have five

physicians, including a representative of the radiologists and pathologists, five hospital representatives, and five representatives of the public on the Blue Cross Board of Directors.

It was brought to the attention of the committee that the study of medical service plans that is being made by Dr. W. H. Howard's Permanent Study Committee on Health Insurance should also be taken into consideration.

Article from *The Wall Street Journal*, pointing to the Michigan Hospital and Medical Service Plan as an alternative plan of socialized medicine, brought to the attention of the committee.

Announcement of Employees Group Insurance Plan of Eli Lilly and Company brought to the attention of the committee. This is a plan similar to the General Motors plan and many other programs that are carried out through commercial companies.

Resolution calling for voluntary plan by Howard County Medical Society brought to the attention of the committee.

Book published by the Social Security Board, entitled, "Prepayment Medical Care Organizations," discussed by the committee. The committee authorized the purchase of ten copies of this book, to be sent to the members of the Executive Committee and to the members of the Permanent Study Committee on Health Insurance.

Plan of Dr. Simon Reisler referred to the Committee on Study of Health Insurance. Each member of the Health Insurance Committee has received a copy of this plan.

Copies of "Community Hospital and Medical Plans," by C. Rufus Rorem, distributed to members of the committee.

Medical Relief

Dr. Eugene Boggs has indicated that he would like to remain on the State Advisory Committee on Medical Aid if the committee can change the time of its meetings.

Future Medical Meetings

Announcement made of the Second Annual Industrial Health Conference, to be held Wednesday and Thursday, April 19 and 20.

Meeting to discuss maternal and child medical service program for servicemen's families, to be held in Colorado on April 28 and 29. The executive secretary was authorized to accept invitation to attend.

Annual session of American Medical Association, Chicago, June 12 to 16. The Executive Committee asked that the delegates and alternate delegates to the A.M.A. be invited to the next meeting of the Executive Committee to discuss problems, questions, and resolutions that might come up at the A.M.A. meeting.

The Journal

The new office of THE JOURNAL is located at 1017 Hume Mansur Building, Indianapolis. Telephone number: Franklin 3895.

Report on meeting of Advisory Committee to the Cooperative Medical Advertising Bureau brought to the attention of the committee.

Report on the Council on Pharmacy and Chemistry of the American Medical Association brought to the attention of the committee.

The committee decided not to carry advertising of Young's Rectal Dilators at the present time.

Professional cards are not to be taken from men who are not members of the state association.

The committee approved the reproduction of a bond on the cover page of the June issue of THE JOURNAL as part of the publicity for the Fifth War Loan drive.

Correspondence with Medical Publications Company, New York, a private concern which desires to handle advertising for THE JOURNAL, brought to the attention of the committee.

Comparison of advertising carried by state journals and medical magazines during 1942 and 1943 brought to the attention of the committee.

Letter received from National Physicians Committee soliciting editorial comment on the booklet, "The American People." In keeping with the policy of the Executive Committee that the state medical association does not officially recognize any of the groups that are formed outside of the A.M.A. to carry on economic work, upon the motion of Dr. Oliphant, seconded by Dr. McCaskey, the committee voted against carrying such editorial comment in THE JOURNAL.

Letter from the secretary of *California and Western Medicine* to the editor of THE JOURNAL of the Indiana State Medical Association brought to the attention of the committee.

The Spencer Corset Company has reduced its advertising in state journals because results show that only a few journal coupons were cut and returned by physicians. Request made by Mr. Sandberg that advertising carrying coupons receive the attention of physicians.

The committee voted its wholehearted approval of the action taken by Dr. Shanklin in representing the state journals on the Advisory Committee to the Cooperative Medical Advertising Bureau. The committee hopes that Dr. Shanklin, through his membership on that committee, will be able to obtain a better break in advertising for state journals.

Medical Defense

Report on group insurance policy. Informal memorandum on malpractice insurance, prepared by Dr. Nafe, distributed to the committee. This is to be the first matter for discussion at the next meeting of the committee.

There being no further business, the meeting was adjourned.



LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

CARROLL COUNTY MEDICAL SOCIETY:

President, M. R. Adams, Flora.
Vice-president, E. H. Brubaker, Flora.
Secretary-treasurer, Charles Wise, Camden.

CRAWFORD COUNTY MEDICAL SOCIETY:

President, N. E. Gobbel, English.
Secretary-treasurer, H. H. Dean.

DUBOIS COUNTY MEDICAL SOCIETY:

President, E. F. Steinkamp, Huntingburg.
Vice-President, Henry G. Bacher, Ferdinand.
Secretary-treasurer, Paul J. Blessinger, Jasper.

GIBSON COUNTY MEDICAL SOCIETY:

President, H. M. Arthur, Hazleton.
Vice-president, B. C. Gwaltney, Fort Branch.
Secretary-treasurer, O. M. Graves, Princeton.

HENDRICKS COUNTY MEDICAL SOCIETY:

President, J. Harold Grimes, Danville.
Vice-President, Rilus E. Jones, Clayton.
Secretary-treasurer, W. T. Lawson, Danville.

JASPER-NEWTON COUNTY MEDICAL SOCIETY:

President, Ralph H. Ruhmkorff, Goodland.
Secretary-treasurer, W. G. Pippenger, Brook.

JAY COUNTY MEDICAL SOCIETY:

President, A. C. Badders, Portland.
Vice-president, H. J. Hiestand, Pennville.
Secretary-treasurer, B. M. Taylor, Portland.

LAKE COUNTY MEDICAL SOCIETY:

President, D. F. McGuire, East Chicago.
President-elect, C. W. Yarrington, Gary.
Secretary-treasurer, H. M. Baitinger, Gary.

MONROE COUNTY MEDICAL SOCIETY:

President, Margaret Owen, Bloomington.
Vice-president, F. H. Austin, Bloomington.
Secretary-treasurer, H. S. Hepner, Bloomington.

PARKE-VERMILLION COUNTY MEDICAL SOCIETY:

President, Paul B. Casebeer, Clinton.
Secretary-treasurer, Charles W. Morris, Rockville.

PERRY COUNTY MEDICAL SOCIETY:

President, H. S. Dome, Tell City.
Vice-president, J. E. Taylor, Leopold.
Secretary-treasurer, E. R. Snyder, Troy.

PIKE COUNTY MEDICAL SOCIETY:

President, J. T. Kime, Petersburg.
Vice-president, T. R. Rice, Petersburg.
Secretary-treasurer, L. R. Miller, Winslow.

RANDOLPH COUNTY MEDICAL SOCIETY:

President, W. S. Diniger, Winchester.
Vice-president, Byron Nixon, Farmland.
Secretary-treasurer, R. B. Engle, Farmland.

RIPLEY COUNTY MEDICAL SOCIETY:

President, I. A. Whitlach, Milan.
Secretary-treasurer, George S. Row, Osgood.

RUSH COUNTY MEDICAL SOCIETY:

President, C. Willard Worth, Milroy.
Vice-President, C. C. Atkins, Rushville.
Secretary-treasurer, W. S. Coleman, Rushville.

VIGO COUNTY MEDICAL SOCIETY:

President, Clyde S. Carmichael, Seelyville.
Vice-president, Robert R. Brown, Terre Haute.
Secretary-treasurer, A. M. Mitchell, Terre Haute.

Delaware-Blackford County Medical Society members held a meeting on April eighteenth at Robert's Hotel. This meeting was a regular business meeting. Dr. L. G. Montgomery, of Muncie, explained the new sedimentation test for hemoglobin, used on prospective Red Cross donors. Twenty-six members attended the meeting.

* * *

Howard County Medical Society members met at the St. Joseph Memorial Hospital, in Kokomo, on April fourteenth. The speaker for this meeting was Dr. W. W. Bourke, of the Veterans' Administration Hospital at Marion, who spoke on "Shell Shock." Nineteen members were present.

* * *

Montgomery County Medical Society members held a dinner meeting at the Culver Hospital in Crawfordsville, on April twentieth. The guest speaker for this meeting was Dr. R. A. Solomon, of Indianapolis, who presented a paper on the "Use of Sulfonamides in General Practice." A general discussion following presentation of the paper, by the seventeen members and guests who attended the meeting.

* * *

Noble County Medical Society members met at Kendallville on May fifth. The twelve members present discussed current business.

* * *

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital, at Clinton, on April nineteenth. Films from the State Board of Health, illustrating obstetrical subjects, were shown. Six members were present at the meeting.

* * *

Putnam County Medical Society members met at Greencastle on May eleventh. This was a routine business meeting. Nine members were present.

* * *

St. Joseph County Medical Society members met at the Indiana Club, in South Bend, on April twentieth. The topic of the evening was "The Diagnosis and Treatment of Coronary Diseases." Sixty-five members and guests were present.

At another meeting on May ninth, Dr. George K. Higgins, of South Bend, spoke on "Needle Biopsies." Fifty-four members and guests were in attendance.

* * *

Tippecanoe County Medical Society members held a regular dinner meeting at the Lincoln Lodge on May ninth, with thirty members present. The evening was devoted to an "Information Please" on urology, with Dr. Percy E. McCown, of Indianapolis, being the "Clifton Fadiman," assisted by Dr. F. S. Crockett and Dr. M. J. Eaton, of Lafayette. The secretary reports that the meeting was such a success that similar discussions will be held via this plan.

Vanderburgh County Medical Society members met at the Hotel McCurdy, in Evansville, on April eleventh. Dr. Paul C. Bucy, of the University of Illinois, gave a most interesting discussion of a newly-developed brain operation which has proved valuable in some forms of mental illness.

* * *

Indianapolis (Marion County) Medical Society members met on May second at the Indianapolis Athletic Club. The following case reports were read: "A Case of Vitamin B Deficiency," by W. A. Shullenberger, M.D.; "Two Cases of Scarlet Fever," by Frances T. Brown, M.D.; "A Case of Banti's Syndrome," by M. R. Shafer, M.D.; "Back Pain Due to Metastasis of Malignant Tumor," by M. H. Mentendick, M.D.; and "Tumor of Chest Wall," by L. W. Nehil, M.D.

On May ninth, Major C. S. Wilson, Chief of Medical Service, Billings General Hospital, was in charge of the meeting. The topic of the evening was "Fever Therapy."

At another meeting on May sixteenth Lieutenant Colonel F. A. Rice, of Billings General Hospital, was in charge of a symposium on "Penicillin." Major E. H. Burford presented "A Resume of Six Hundred Cases of Sulfa-Resistant Gonorrhea," and Lieutenant Colonel G. C. Struble spoke on "Some Observations on the Local Use of Penicillin in Infections of the Eye and Middle Ear." "A Review of Medical Cases Treated with Penicillin" was presented by Major C. S. Wilson, who spoke on cases treated at the Billings General Hospital, and Drs. Philip L. Kurtz, F. B. Peck, and G. F. Kempf, all of Indianapolis, discussed cases treated at the Indianapolis City Hospital.

F. L. Jennings, M.D., was the moderator of a symposium on tuberculosis, which was the topic of the May twenty-third meeting. The panel group was made up of Drs. W. S. Tucker, James D. Peirce, John V. Thompson, James S. McBride, and Chester A. Stayton.

COUNCILOR DISTRICT REPORT

ELEVENTH COUNCILOR DISTRICT

The regular semi-annual meeting of the Eleventh Indiana Councilor District Medical Association was held in Wabash on May 17, 1944. "Continuous Caudal Anesthesia," was discussed by D. C. Hines, M.D., of Indianapolis; "Pain and the Functional Diseases of the Digestive Tract," by J. E. Culp, M.D., of Fort Wayne; and "Diseases of the Tongue," by Russell Sage, M.D., of Indianapolis. Forty-three physicians attended the meeting.

The following officers were elected: President, F. B. Mitman, Huntington; secretary-treasurer, O. G. Brubaker, North Manchester.

Dr. Ira E. Perry, of North Manchester, tendered his resignation as councilor, and Dr. C. S. Black, of Warren, was elected to fill the unexpired term of Dr. Perry.

METHODS FOR MEDICAL CARE DEBATED

According to the *Muncie Star* of April twenty-ninth, audience interest ran high at an open forum, sponsored by the Public Affairs Committee of the Y.W.C.A., in which the Wagner-Murray-Dingell Bill was discussed by Dr. Loren E. Kerr, commissioner of the Loraine County Health District, Oberlin, Ohio, and Dr. F. S. Crockett, of Lafayette. Dr. Robert LaFollette, moderator, read the preamble of the bill, and predicted before, and after the forum affirmed, that the two physicians, Dr. Kerr, *pro*, and Dr. Crockett, *con*, were more or less in agreement on one of the major objects of the bill—*health care for more people*—but not on the methods of achieving the object.

Dr. Kerr's first point was the determination of the need for medical care, showing the extent and amount of illness among the people of the United States, stating that an average of 2,000,000 men and women are away from their jobs each day because of illness, and that these workers lose 600,000,000 work days per year, in which time 29,000 heavy bombers could be manufactured. He further stated that documentary proof shows that one-third of the people of this county have no medical care—one-half of the first 3,000,000 men called by Selective Service were rejected because of health defects which were remediable. Depending upon the times, 55 to 80 per cent of the people do not have money enough to buy medical care.

He discussed the economics of the Wagner-Murray-Dingell Bill, which would provide medical and hospital care. He said that the total expenditure for medical care now is three and one-half to four billion dollars a year, which means that the individual pays three per cent of his annual income for medical care, whereas under the provisions of this bill the same three per cent would be spent for medical care that would be distributed to 110,000,000 people. Both employers and employees would each pay six per cent up to the first \$3,000 earned, equaling twelve per cent, but the medical service distribution would be increased so as to cover thousands more people. He said "one-fourth, or three per cent, goes for the medical care provisions of the bill, it is not to be referred to as a tax, since the same amount is already being paid. Depending upon the times, fifty-five to eighty per cent of the people do not have money enough to buy medical care now; by this bill the earner and his dependents would benefit by his payments." Dr. Kerr said, "There are three solutions to the health problem: the voluntary approach, the increase of taxes, and compulsory insurance."

"Political Medicine" was the term given to the bill by Dr. Crockett, the second speaker, who objected to the solution of the problem by compulsory means, and who stated that it would be better to

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(Continued from page 340)

make a voluntary solution. He said that it would result in Government domination of medicine, and he inferred that since medicine would be "public service," the quality of service would deteriorate.

Dr. Crockett pointed to the German system of state medicine as an example, which, he said, had called for the employment of more lay people than doctors in the last fifty years. He decried the numbers of Government employes the medical care section of the bill alone would entail, and stressed the opportunity the program would give for politics. He said the bill provides for the Surgeon-General of the United States to choose doctors who would take part in the program.

Red tape would result from the many forms that it would be necessary for participating doctors to fill out, and he stated that if a change of physician were desired by the patient, the procedure would involve the filling out of forms.

The physician who would serve you, Dr. Crockett said, would be assigned to you, and there would be no free choice. He emphasized the change in patient-physician relationship that would follow as the result of not paying the doctor for service rendered.

He questioned the clarity of the bill in the thirty days of hospitalization granted. He said it was not precisely stated whether the thirty days was per family or per individual of the family.

WOMAN'S AUXILIARY

to the

Indiana State Medical Association

President—Mrs. James Baxter, Jr., New Albany
 President-elect—Mrs. F. M. Gastineau, Indianapolis
 Corresponding Secretary—Mrs. John Habermel, New Albany
 Treasurer—Mrs. A. W. Ratcliffe, Evansville
 Press and Publicity—Mrs. A. B. Richter, Indianapolis

The board of directors of the Woman's Auxiliary to the Indiana State Medical Association met at the Columbia Club, in Indianapolis, at 10:30 A.M., May third. Mrs. James Baxter, Jr., presided at a strictly business meeting which adjourned at 4:00 P.M. There was an intermission at 12:30 for lunch. Twenty-six board members were present for this meeting; a commendable number considering the distance and inconvenience of travel these days.

County and committee reports were given by the respective chairmen. After hearing the reports it was agreed that the Indiana auxiliaries can be proud of this year's record, despite many handicaps. Most all of the auxiliaries reported many hours spent in various Red Cross activities and other war participation services. The Wagner-

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MEDICINE—Two Weeks Personal Course in Electrocardiography & Heart Disease starting August 7. Two Weeks course Internal Medicine starting October 16.

GYNECOLOGY—Two Weeks Intensive Course starting October 2. One Week Personal course Vaginal Approach to Pelvic Surgery starting October 23.

OBSTETRICS—Two Weeks Intensive Course starting June 26.

ANESTHESIA—Two Weeks Course Regional, Intravenous & Caudal Anesthesia.

GASTROSCOPY—Personal Course starts October 16.

OTOLARYNGOLOGY—Two Weeks Intensive Course starts October 2.

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Murray-Dingell Bill has been studied by practically every medical auxiliary, and at least one meeting has been devoted to this subject.

The special Finance Committee presented suggestions of correction to the problem of the National Auxiliary request that our State fiscal year conform more closely with the National auxiliary fiscal year. In order to do this it will be necessary to make some changes in our present Constitution. These changes were discussed at length, and board members were asked to study the suggestions further. The revisions will come up for acceptance by the State auxiliary at the annual convention in October.

The past presidents and our president now possess the pins which were purchased this summer. It is fitting that they have them in time for the National Convention in June. They are pins that every auxiliary member can be proud our president possesses.

Mrs. Baxter made several suggestions for the future:

1. Post-war planning. Start now with a post-war committee. There will be new adjustments after the war. Doctors' wives should have a prominent part in making peace. The present work should be continued.
2. Procure members-at-large for counties not able to have their own organization. This will be the means of organization after the war.
3. Another worth-while project which could be considered by auxiliaries is the blood typing of children.

The National Convention will be held in Chicago June 12-15. Headquarters will be in the Knickerbocker Hotel. Those desiring to attend the convention should get reservations at once if they have not already done so. Indiana will have eight delegates at the convention. Mrs. A. W. Ratcliffe, of Evansville, is the chairman of the Indiana delegates.

The Annual State Convention will be held in Indianapolis October 3-4. We hope that you will start now in making plans to come to this meeting. We have had a successful year—let us all be together at this meeting!

Will County Presidents *please* get their annual reports in to Mrs. James Baxter, Jr., New Albany? Most reports are in—but we want *all* of them!

ALLEN COUNTY

Mrs. James Baxter, Jr., and members of the Auxiliary to the Northeastern Indiana Academy of Medicine were guests of the Woman's Auxiliary to the Allen County Medical Society at a recent

meeting at the home of Mrs. William Gessler. A musical program was enjoyed.

HOWARD COUNTY

Members of the Woman's Auxiliary to the Cass County Medical Society were guests of the Howard County Auxiliary at a meeting at the home of Mrs. Thomas Conley, April fourteenth. Mrs. James Baxter, Jr., was the guest speaker. She spoke on the objectives of the state organization and urged work in war participation and post-war planning.

MARION COUNTY

The members of the Auxiliary to the Marion County Medical Society entertained their husbands with a "home talent" show in the auditorium of the Methodist Hospital Nurses' Home on May third. At this event the mothers and fathers had an opportunity to see their own children perform. Mrs. G. W. Gustafson, the president, acted as master of ceremonies, and gaily presented the offspring. A variety of talent was displayed, including humorous reading, tap and ballet dancing, singing, piano, violin and trumpet arrangements. One of the Marion County doctors conducted a band. All in all, it was an evening everyone hopes will be duplicated next year.

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—April, 1944

DISEASES	April 1944	Mar. 1944	Feb. 1944	April 1943	April 1942
Tuberculosis, Pulmonary	255	146	161	222	115
Tuberculosis, Other Forms.....	3	0	2	29	11
Chickenpox	592	661	629	507	460
Measles	1185	1103	1135	2103	573
Scarlet Fever	972	848	620	345	450
Smallpox	2	3	10	5	3
Typhoid Fever	6	16	174	0	3
Whooping Cough	49	67	105	330	181
Diphtheria	23	33	37	16	22
Influenza	24	52	73	141	97
Pneumonia	27	40	46	48	80
Mumps	268	238	261	411	161
Poliomyelitis	1	1	2	2	2
Cerebrospinal Meningitis	38	37	39	39	3
Nonepidemic Meningitis	1	0	1	1	1
Undulant Fever	6	5	9	8	4
Rubella	29	14	10	1347	80
Vincent's Angina	4	2	0	175	1
Conjunctivitis	2	0	0	0	0
Dysentery	27	0	0	1	0
Malaria	4	10	4	2	0
Septic Sore Throat.....	24	23	3	0	0
Erysipelas	1	1	0	0	0
Ophthalmia Neonatorum	1	0	0	0	0
Encephalitis Lethargica	2	0	0	0	0

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASE CONTROL
MORBIDITY REPORT FOR 1943 BY MONTHS FOR INDIANA

	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
Tuberculosis, Primary	2	79	15	18	25	14	7	11	3	1	14	21	210
Tuberculosis, Active	99	206	196	222	328	235	218	106	88	326	128	300	2452
Tuberculosis, Arrested	5	24	10	11	72	15	35	22	19	42	26	16	297
Chickenpox	380	421	442	507	370	150	21	15	32	205	314	222	3079
Measles	690	1094	1341	2103	2248	1133	344	60	39	186	407	460	10105
Scarlet Fever	450	423	380	345	302	131	59	34	79	281	265	239	2988
Smallpox	49	29	16	5	7	5	3	1	.....	2	9	3	109
Typhoid Fever	6	2	6	.....	8	9	24	10	10	12	2	3	92
Whooping Cough	109	168	182	330	320	248	310	193	171	109	111	92	2343
Diphtheria	27	18	20	16	23	13	8	28	26	66	67	32	344
Mumps	217	475	308	411	483	110	44	23	20	49	115	74	2329
Poliomyelitis	3	1	.....	2	1	1	3	12	37	27	2	.....	89
Cerebrospinal Meningitis	9	10	20	39	34	23	7	19	5	23	13	25	227
Nonepidemic Meningitis	.....	.....	.....	1	.....	.....	.....	1	.....	.....	.....	1	3
Trachoma	1	.....	1	.....	.....	.....	.....	1	.....	1	1	.....	5
Tularemia	10	2	.....	.....	.....	.....	.....	.....	.....	.....	2	5	19
Vincent's Angina	2	.....	1	175	.....	.....	.....	.....	.....	.....	1	.....	179
Rubella	181	1177	868	1347	320	65	24	14	4	4	8	120	4132
Undulant Fever	1	.....	1	8	8	6	7	8	6	8	5	3	61
Rocky Mountain Spotted Fever	1	.....	.....	.....	.....	2	2	.....	3	1	.....	.....	9
Rabies in Man	1	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	2
Encephalitis, Noninfectious	1	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	2
Encephalitis, Lethargica	.....	1	.....	.....	.....	.....	.....	.....	.....	2	2	.....	5
Malaria	.....	.....	1	2	2	1	12	9	1	12	3	1	44
Tetanus	.....	.....	.....	.....	.....	2	.....	.....	.....	.....	.....	.....	2
Erysipelas	.....	.....	1	.....	.....	1	.....	.....	.....	.....	1	.....	3
Pellagra	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	1
Typhus Fever	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	1
Epidemic Keratoconjunctivitis	.....	.....	.....	.....	.....	.....	12	.....	.....	.....	.....	.....	12
Coccidioidomycosis	.....	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	1
Influenza	48	83	52	141	39	6	19	14	17	28	65	2431	2943
Pneumonia	68	125	61	48	70	25	12	7	23	34	26	42	541
Septic Sore Throat	4	2	3	2	11
Diarrhea	73	73
Dysentery, Unclassified	1	14	2	17
Impetigo	3	3

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THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

JULY, 1944

NUMBER 7

PRIMARY TUBERCULOSIS

EDWARD W. CUSTER, M.D.*

SOUTH BEND

The term, "Primary Tuberculosis" has become familiar, but a certain amount of confusion still exists concerning its importance. Our experience in this county with food-handlers and parents of high school students indicates that many of the positive tuberculin-reactors have an incorrect view of their condition due, in some cases, to faulty professional advice.

Infection by tubercle bacilli of types other than the human variety now is negligible. In practically all cases the organisms are air-borne, since the elimination of cattle as carriers has been accomplished by tuberculin testing and pasteurization of milk. There is fairly unanimous agreement that the portal of entry is almost always the respiratory system; the primary focus is in the lung, rarely in the intestine, or more unusually in the tonsils.

It has long been recognized that there are two fairly distinct types of reaction within the human body to infection by the tubercle bacillus—primary tuberculosis and re-infection. The first is the one with which we are chiefly concerned in this discussion.

During their journey through the upper respiratory passages, the organisms are subject to the protective action of nasal and bronchial mucus and the movements of cilia. If they succeed in passing these barriers they lodge in an alveolus or terminal bronchiole, usually in one of the lower lobes or in the lower part of one of the upper lobes. However, this location is by no means constant; primary foci in the upper parts of the upper lobes are not rare, and secondary lesions in the lower lung fields are fairly common. A diagnosis of primary or secondary tuberculosis should therefore never be made on the basis of location alone; other important factors must be considered.

Another thing about primary tuberculosis worth emphasizing is that it may occur at any age. It is

frequently found in adults, and conversely, the secondary type is occasionally found in children. For this reason the terms "childhood" and "adult" tuberculosis have been discarded.

The response of the host to this original bacterial invasion is an out-pouring of lymphocytes and monocytes to form the typical Gohn tubercle. These cells attempt to wall off and destroy the organisms, but the powers of resistance are rarely quite adequate to localize the infection immediately. In practically every case the inflammatory process extends along the lymph channels to the neighboring tracheobronchial or mediastinal glands, thus forming the well known "primary complex of Ranke." This lymph node involvement is more constant and typical of first-infection tuberculosis than is the location of the lesion. Lymph nodes are rarely affected by the secondary variety of disease.

Perhaps the most important factor of the primary phase is the development of allergy. The tissues become sensitive to the proteins of the tubercle bacillus and thus their reaction to further infection is modified. It is this allergic state which marks the essential difference between the two phases of tuberculosis. Further implantation of tubercle bacilli (re-infection) in these sensitized tissues calls forth a different response; local tissue destruction is more severe, but there is less tendency to spread. The tuberculin test is simply a qualitative method of detecting the presence of this sensitivity of the body to tuberculo-proteins.

In tuberculosis, allergy and immunity apparently have a relationship, but it is not direct and may even be merely coincidental. The situation is still confusing, but many consider this sensitized state at least a partial protection to further exogenous infection. Some sanatoria, for example, do not employ individuals with negative tuberculin reactions. Personally, I doubt whether it is ever an asset to anyone to be infected with tuberculosis. At any rate, the degree of allergic response, as demon-

* Medical Director and Superintendent, Healthwin Hospital, South Bend, Indiana.

strated by the tuberculin test, is certainly not an indication of resistance.

In this regard it may be stated that the primary complex itself is not innocuous. Approximately one or two per cent of these lesions spread, either by extension through contiguous tissues, through lymph channels, the blood vessels, or bronchi. The location and extent of metastasis depends upon the route of dissemination, the number of bacilli liberated, and the resistance of the host. At first glance this figure does not seem large, but one per cent of all the primary infections in a community makes a significant number of cases.

For quite some time, phthisiologists and pediatricians talked of a condition called "epituberculosis," which was supposed to be a gelatinous or tuberculous pneumonia complicating primary infection. This is usually seen on the x-ray plate as a uniformly dense shadow, lobar or lobular in extent. Frequently these so-called "patches of consolidation" undergo spontaneous resolution within a relatively short time, contrary to experience with other types of tuberculous pneumonia. Now, in the light of recent investigations, we know that these areas are atelectatic due to intrinsic constriction of the bronchial lumen from tuberculosis of the wall of this structure, or extrinsic compression from enlarged lymph glands adjacent to the bronchus. As the tuberculous process improves, the airway becomes patent and the corresponding section of the lung again becomes aerated, if the condition has not existed so long that secondary infection and fibrosis have produced permanent collapse.

The primary focus may extend through the wall of a bronchus and its caseous center may be discharged, leaving a pulmonary cavity. The exudate may be carried to other parts of the lung to form tuberculous bronchopneumonia. Likewise, an infected tracheobronchial node may erode a bronchus to cause bronchogenic spread. If the tuberculous lesion, either in the lung or a gland, gets into the blood stream, hematogenous dissemination is the result. If great numbers of bacilli are discharged or the resistance of the host is low, miliary tuberculosis develops. The organisms may be seeded into almost every organ; meninges, kidney, and bone marrow are the most frequent sites. Blood-stream metastasis is due more often to primary infection than to re-infection, although cavitation and bronchogenic spread are more common in the latter.

However, immediate spread is not the chief danger of first-infection disease. The majority of these lesions tend to heal, but the degree of healing may be only relative. Sometimes complete resolution may take place, but more often the area caseates, becomes surrounded by a fibrous capsule, and later calcifies. Unfortunately, the tubercle bacillus is extremely resistant. It may remain alive within its cell for many years, only to break out again during a period of lowered resistance due to malnutrition, overwork, debilitating illness, et cetera. This is the theory of endogenous re-infection in contrast to exogenous re-infection, or additional infection from

without. No doubt both mechanisms may be responsible for the secondary type of disease, but it is interesting to note that most experts support the endogenous method as the one responsible for the majority of breakdowns. It may be well to consider many adult cases as exacerbations of the original involvement rather than re-infection. Incidentally, the word "inactive," rather than "healed," should be used to describe these old primary lesions, since there is no certain way to determine when organisms contained therein are dead.

The diagnosis of a primary lesion depends chiefly upon the result of tuberculin testing and the x-ray. A positive tuberculin test means that infection by the tubercle bacillus has occurred. An x-ray is necessary to determine whether a clinically significant lesion is present. A history, physical examination, and laboratory studies are required to detect activity of the disease.

There are several modifications of the tuberculin test; two kinds of solution and two technics of administration are in general use. Old Tuberculin is a filtrate prepared originally by Koch, and is still the more sensitive preparation. It is used when higher concentrations are desired in differential diagnosis. Purified Protein Derivative (P. P. D.) has been developed more recently. It is slightly more expensive, but is more stable and the dosage is therefore more uniform. This is the solution recommended for general use. The intradermal puncture technic of Mantoux, using either Old Tuberculin or P. P. D., is the most widely-accepted method of administration. It is practically painless, is accurate, and is easy to do. Quite recently the Vollmer Patch Test has become popular, chiefly because it is entirely painless and requires no equipment. Small squares of gauze impregnated with tuberculin are placed in direct contact with the skin by means of adhesive. This method is valuable, but requires care in application; the skin must be carefully cleansed and the patch maintained securely in close approximation to the skin. For differential diagnosis, a second-strength P.P.D. or Old Tuberculin should supplement either the patch test or first-strength Mantoux reaction. It is not wise to use the more concentrated solution unless the first-strength has been found negative, because of danger of severe local or general reactions.

The tuberculin test is not infallible because the allergic state upon which it depends varies. Early in the disease, and in the presence of overwhelming infection, sensitivity may be absent. Sometimes a reaction can be demonstrated only by the use of highly-concentrated solutions. If all the bacilli within the body die, antibodies may disappear, and a negative reaction will result. Repeated primary infections are not unknown.

In the x-ray, primary lesions appear as small infiltrations, usually in the middle or lower lung fields. They may be accompanied by visible enlargement of the hilar or mediastinal shadows representing infection of the tracheobronchial glands.

If healing takes place by resolution, no trace will remain visible on the film. If the usual fibrotic or calcified scar is within the portion of the lung not shown by routine plates, or if it lies behind a dense object like a rib, it may not be seen. Care must be exercised not to interpret small round markings within the hilar regions as calcifications; frequently these shadows are only blood vessels. Most but not all calcifications are tuberculous in origin; there are other conditions which can produce caseous necrosis, which is the prerequisite for deposition of lime salts. Neither are all calcifications the result of first infections; many secondary lesions calcify, contrary to earlier teachings. It is frequently impossible to decide whether a lesion is primary or a re-infection unless recent tuberculin tests and x-rays are known to be negative.

The diagnosis of activity of a primary lesion is usually more difficult than its discovery. Constitutional symptoms, such as fever and fatigue, are important when present, but their absence is not conclusive proof that the disease is inactive. The x-ray film is a valuable aid. A soft, fluctuating lesion may be assumed to be active, but calcification is not necessarily a sign of inactivity since there may be an active process adjacent to the calcified area. No general agreement exists as to a method of determining the age of lesions, but we do know that calcifications may occur in less than a year. Sputum studies, including gastric lavage with guinea pig inoculation, may be advisable to detect the presence of tubercle bacilli. Certainly it is conservative to consider any lesion less than one year of age as probably active.

Pronouncement of a diagnosis of primary tuberculosis, especially in a child, carries with it a definite responsibility to the health of the community. The infection must come from someone; and the younger the child, the closer the contact is apt to be. Consequently, the family of every posi-

tive reactor should be examined in an effort to discover the open case which may have served as the source of infection. Usually the search for contacts, and the duty of explaining the necessity for their examination, falls upon a visiting public health nurse or social worker, since experience has shown that the average physician does not have the time to carry out this part of the program. Each reactor, therefore, should be reported to the Tuberculosis League or the Department of Health, so that adequate investigation can be made.

It is also necessary that the individual with a primary infection be treated for it, and that his danger be recognized. The amount of treatment required depends upon the activity and extent of involvement. Fortunately, the disease is usually mild, especially in childhood, when the majority of original infections occur. When the lesion is limited and symptoms are slight, a modified rest program is indicated until the process becomes inactive. After this, only general hygienic precautions and restriction of strenuous exercise, plus periodic observation, is necessary. However, it is advisable to take x-ray films of the chest at intervals not exceeding one year, from puberty to the age of thirty-five, in order to detect early any exacerbation of the tuberculous lesion. Severe infections, of course, may require special measures, occasionally even collapse therapy.

In conclusion, it may be said that tuberculosis, regardless of the type of infection, is always a serious matter. A positive tuberculin reaction, or x-ray evidence of a tuberculous lesion—primary or secondary—is evidence of a potentially dangerous disease. The patient should never be told he is “all right” and to “forget it.” Periodic x-ray examination is always indicated, and certain restrictions of physical activities, as well as other precautions, may be advisable.

ABSTRACT: REPORT PENICILLIN IS EFFECTIVE IN TREATMENT OF BRAIN INFECTION

Two reports of successful treatments with penicillin—one of three cases of brain infection and another of an abscess of the liver—are published in *The Journal of the American Medical Association* for March 4.

Captain Albert L. Evans, Medical Corps, Army of the United States, in reporting the treatment with penicillin of three cases of brain infection, points out that “Until the advent of the sulfonamides it was rare for persons with pneumococcal or staphylococcal meningitis to survive. Reports of such survivals have appeared in the literature more frequently since these agents have been used, but penicillin seems to offer more hope for cure of these maladies than any other substance known at the present time. Two cases of staphylococcal meningitis and one case of pneumococcal meningitis are herewith reported as having been cured with penicillin at Lawson General Hospital. It is felt that survival would not have occurred with the types of therapy in practice prior to the advent of penicillin.”

Paul H. Noth, M.D., and John Winslow Hirshfeld, M.D., Detroit, report the successful treatment of an amebic abscess of the liver which had become secondar-

ily infected, by means of the injection of penicillin into the abscess.

They say that “The results in this case have been encouraging. It is hoped that those who have similar cases will employ this method of treatment in order to determine whether it will be possible to avoid open drainage in secondarily-infected amebic abscesses of the liver.”

As Drs. Noth and Hirshfeld point out, open drainage of such abscesses carries with it a high fatality rate.

In a symposium, published in the same issue of *The Journal* under the auspices of the Association's Section on Experimental Medicine and Therapeutics, the need for a conservative attitude toward the possibilities of penicillin is emphasized by several authors.

Wallace E. Herrell, M.D., Rochester, Minnesota, concludes his report with the advice that “Penicillin should be reserved so far as possible for infections resistant to sulfonamide compounds. Penicillin therapy is no substitute for sound medical and surgical judgment in the treatment of bacterial infections.”

THE MODERN TREATMENT OF CYANIDE POISONING

K. K. CHEN, M.D.*

CHARLES L. ROSE, B.A.*

G. H. A. CLOWES, Sc.D.*

INDIANAPOLIS

SOURCES OF POISONING AND MORTALITY STATISTICS

Hydrocyanic acid and its alkali salts are highly potent poisons but essential products to industry and sanitation.[†] Sodium or potassium cyanide is extensively used in metallurgy for extraction of gold and silver from their ores, in electroplating, for cleaning of metal by both the dip and the electrolytic processes, for organic synthesis, for dehairing hides, and for partial sterilization of soil.

Hydrocyanic acid is a most effective agent for the fumigation of ships,¹ army posts,² navy stations, large buildings, flour mills,³ and private dwellings which have been infested with mice, rats, moths, bedbugs, cockroaches, or carpet beetles. It is also used for the control of scale insects on citrus trees.⁴ Various commodities, such as nut meals, beans, peas, seeds of different kinds, and baled cotton, are fumigated with hydrocyanic acid in vacuum chambers.

The United States Department of Agriculture requires the fumigation of imported cotton and supervises the fumigation of railway freight cars on the Texas-Mexican border.

In spite of the tremendous amount of cyanide and hydrocyanic acid used commercially per annum, relatively few cases of poisoning occur. This is undoubtedly due to the incessant warning of the manufacturers and the care exercised in handling hydrocyanic acid by workers and fumigators. City and health department regulations have also contributed much to the safety of fumigation.⁵

The cause for the majority of deaths from cyanide poisoning has been suicide. For example, in the County of Essex, New Jersey, which has an

average population of 700,000, there were eighty-eight deaths from cyanide poisoning for the years 1920 to 1942, inclusive, as recorded by Dr. Albert E. Edel (Table I). Every one of them was suicidal in origin. Similarly, suicidal deaths from cyanide poisoning in Continental United States constitute 89 to 98 per cent of the total deaths from cyanide poisoning, as shown in Figure I. The early data in this chart were compiled from *Mortality Statistics*,⁶ and the figures for the years 1934 to 1941 were kindly furnished by Drs. Halbert L. Dunn and J. C. Capt, Bureau of Census, Department of Commerce, Washington, D. C. The predominance of suicidal deaths from cyanide poisoning is also borne out in the records of the Chief Medical Examiner, New York City. Figure II, illustrating this fact, is constructed from the published work of Gettler and St. George,⁷ and from the data for 1934 to 1941 generously supplied by Dr. Thomas A. Gonzales. The year 1919 was the only one in which accidental deaths (including industrial) exceeded suicidal deaths. As evidenced in both Figures I and II, the peak of suicides from cyanide poisoning coincided with the height of the economic depression, namely, 1933.

Deaths from gaseous hydrocyanic acid, which is chiefly handled by fumigators and chemists, are, on the average, more frequently accidental than suicidal. Table II includes statistics on deaths from this cause, which were generously supplied by Dr. Capt. From 1930 to 1935, suicidal deaths were not specifically tabulated and therefore are not shown here. In only one year, namely 1940,

TABLE I

DEATHS FROM CYANIDE POISONING IN THE COUNTY OF ESSEX, NEW JERSEY

Year	Number	Year	Number
1920	4	1932	5
1921	3	1933	6
1922	2	1934	2
1923	7	1935	7
1924	2	1936	1
1925	3	1937	8
1926	4	1938	3
1927	1	1939	3
1928	1	1940	2
1929	5	1941	1
1930	6	1942	3
1931	9		
		Total	88

* From the Lilly Research Laboratories, Eli Lilly and Company, Indianapolis.

† We are indebted to Mr. L. L. Lehritter, of New York City, and Dr. B. H. Vollertsen, of Niagara Falls, New York, for furnishing information on the industrial uses of cyanide and hydrocyanic acid.

¹ Jennings, H. E.: The Disinfestation of Ships by Fumigation, *U. S. Nav. Med. Bull.*, **41**:1477, 1943.

² O'Donnell, J. E.; Mundt, H. W.; Knudsen, W. N., and Delano, P. H.: Hydrogen Cyanide Gas Fumigation, *J. Indust. Hyg. and Toxicol.*, **22**:253, 1940.

³ Cotton, R. T.; Young, H. D., and Wagner, G. B.: Fumigation of Flour Mills with Hydrocyanic Acid Gas, *J. Econ. Entomol.*, **29**:514, 1936.

⁴ Carlisle, P. J.: Manufacture, Handling and Use of Hydrocyanic Acid, *Indust. and Engin. Chem.*, **25**:959, 1933.

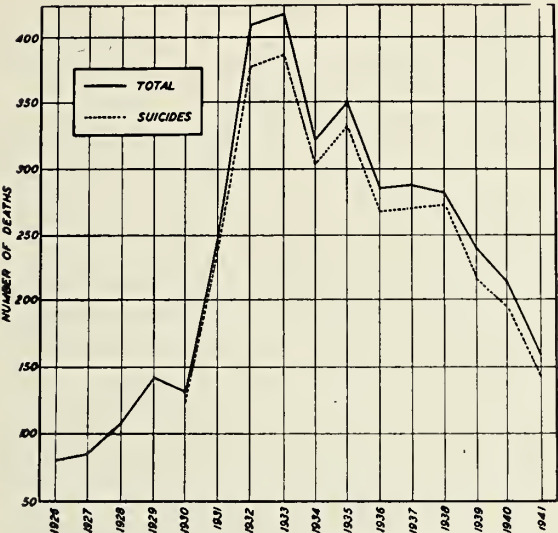
⁵ Cousineau, A. and Legg, F. G.: Hydrocyanic Acid Gas and Other Toxic Gases in Commercial Fumigation, *Am. J. Pub. Health*, **25**:277, 1935.

⁶ *Mortality Statistics*, Bureau of Census, U. S. Dept. of Commerce, Washington D. C. 1926-1933.

⁷ Gettler, A. O., and St. George, A. V.: Cyanide Poisoning, *Am. J. Clin. Path.*, **4**:429, 1934.

FIGURE I

DEATHS FROM CYANIDE POISONING
IN THE UNITED STATES



did suicides surpass accidents from poisoning with gaseous hydrocyanic acid.

The employment of cyanide for purposes of murder has been rare. In New York City, as shown in Figure II, there were only 5 homicides

TABLE II

NUMBER OF DEATHS FROM GASEOUS HYDROCYANIC ACID:
UNITED STATES REGISTRATION STATES, 1930-1932,
AND UNITED STATES, 1933-1941

Year	Accidental	Suicidal
1930	16	....
1931	13	....
1932	4	....
1933	6	....
1934	9	....
1935	14	....
1936	15	5
1937	15	4
1938	14	9
1939	15	8
1940	11	15
1941	21	9
Total	153	50

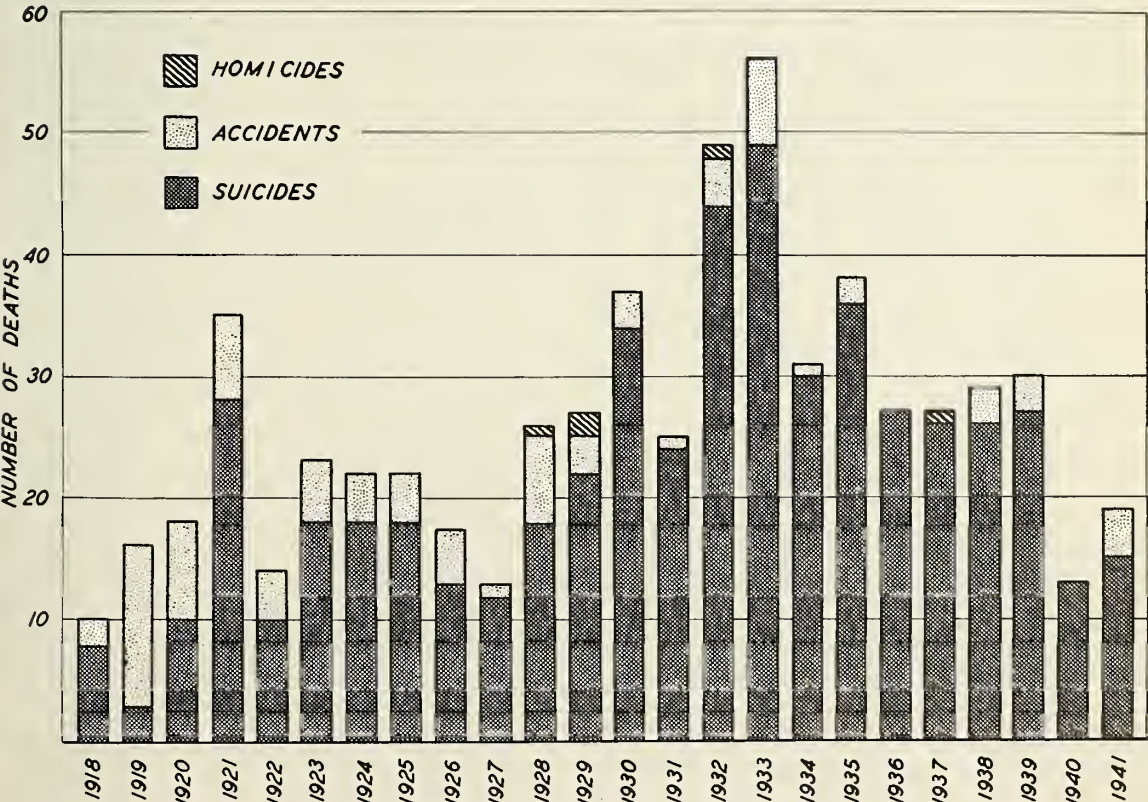
out of 624 cyanide deaths in twenty-four years. They are distributed as follows: 1 in 1928, 2 in 1929, and 1 each in 1932 and 1937. In World War I, the French used hydrocyanic acid shells in the Battle of the Somme, July 1, 1916,⁸ but found it to be less effective than other war gases.

In almost all cases of poisoning, the offending agent enters the body either by ingestion or

⁸Prentiss, A. M.: *Chemicals in War*, McGraw-Hill Book Company, Inc., New York (1st ed.), 1937.

FIGURE II

DEATHS FROM CYANIDE AND HYDROCYANIC ACID POISONING IN NEW YORK CITY



inhalation. It can be stated, however, that hydrocyanic acid may be absorbed through the skin^{9, 10} or the genito-urinary tract¹¹ to produce toxic symptoms. Indeed, death may rapidly follow the introduction of hydrocyanic acid into the urinary bladder.¹²

Certain plants produce free hydrocyanic acid or cyanogenetic glycosides which may become a source of poisoning to man or animals. It is said that the formation of hydrocyanic acid in these plants is due to their inability to convert all the available amino acids into proteins, and is thus a side reaction in protein metabolism.¹³ Bitter almonds, seeds of cherry, plum, peach, apricot, apple, and pear, cassava,¹⁴ and certain bamboo sprouts¹⁵ are all capable of inducing symptoms of cyanide poisoning in human subjects when taken in sufficient quantities. Chokecherry, arrow grass, Sudan grass, and sorghum have been responsible for deaths of livestock owing to their hydrocyanic acid content.^{16, 17, 18, 19, 20} Poisoning by chokecherry seeds in man has also been reported.²¹

DIAGNOSIS

To establish a case of cyanide poisoning before death, positive proof of the presence of cyanide, by chemical tests, in body fluids is necessary, but to make an immediate, tentative diagnosis, circumstantial evidence is usually sufficient. If a person works with cyanide or if he is in the neighborhood of fumigation and is suddenly taken ill, a suspicion of cyanide poisoning is justifiable. Or, if

he is discovered unconscious, and a cyanide container is found nearby, suicidal intent may be considered probable. Clinically, the odor of bitter almond oil in breath is highly suggestive of cyanide poisoning. On the other hand, its absence does not rule out the possibility of cyanide poisoning. Other signs, while not specific or pathognomonic, consist of rapid respiration, later slow and gasping, accelerated pulse, vomiting, and convulsions which are followed by coma and cyanosis. The toxic effect of cyanide is due to the suppression of cellular respiration by inhibiting the action of catalysts which promote the utilization of oxygen.^{22, 23} The latter remains unabsorbed from the capillaries, and the venous blood appears bright red. Cyanosis is therefore a late manifestation, occurring when circulatory failure is approaching. If a person is suspected of having taken the poison by mouth, his stomach contents should be emptied and analyzed. If he is poisoned by gaseous hydrocyanic acid, a 20 cc. sample of venous blood should be drawn and similarly examined. The well-known chemical methods for testing cyanide have been previously enumerated.^{24, 25}

THE NEW TREATMENT

A number of remedies have been proposed for the treatment of cyanide and hydrocyanic acid poisoning, the literature having been reviewed some time ago.²⁶ Results obtained in animals by several groups of investigators^{26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36} indicate that the combination of

⁹ Walton, D. C., and Witherspoon, M. G.: Skin Absorption of Certain Gases, *J. Pharmacol. and Exper. Therap.*, **26**:315, 1926.

¹⁰ Fairley, E. C.; Linton, E. C., and Wild, F. E.: The Absorption of Hydrocyanic Acid Vapour through the Skin, *J. Hyg.*, **34**:283, 1934.

¹¹ Robinson, G. D.: Absorption from the Vagina, *J. Pharmacol. and Exper. Therap.*, **32**:81, 1927-1928.

¹² Holzer, F. J.: Mord durch Einspritzung von Blausäure in die Weiblichen Geschlechtsstelle, *Deutsche Ztschr. f. d. ges. gerichtl. Med.*, **32**:245, 1940.

¹³ Rosenthaler, L.: Zur Prüfung der Treubischen Hypothese, *Biochem. Ztschr.*, **190**:168, 1927.

¹⁴ Turnock, B. J. W.: An Investigation of the Poisonous Constituents of Sweet Cassava (*Manihot utilisima*) and the Occurrence of Hydrocyanic Acid in Foods Prepared from Cassava, *J. Trop. Med. and Hyg.*, **40**:65, 1937.

¹⁵ Autret, M.: Présence d'un glucoside cyanogénétique dans les pousses de bambous, *Rev. méd. franc. d'Extreme-Orient*, **17**:1039, 1939.

¹⁶ Marsh, C. D.; Clawson, A. B., and Roe, G. C.: Arrow Grass (*Triglochin maritima*) as a Stock-Poisoning Plant, *U. S. Dept. Agric. Tech. Bull.*, No. **113**, **1**, 1929.

¹⁷ Beath, O. A.; Draize, J. H., and Eppson, H. F.: Arrow Grass. Chemical and Physiological Considerations, *Univ. Wyo. Agric. Expt. Sta. Bull.* No. **193**, **3**, 1933.

¹⁸ Boyd, F. T.; Aamodt, O. S.; Bohstedt, G., and Truog, E.: Sudan Grass Management for Control of CN-Poisoning, *J. Am. Soc. Agron.*, **30**:569, 1938.

¹⁹ Martin, J. H.; Couch, J. F., and Briese, R. R.: Hydrocyanic Acid Content of Different Parts of the Sorghum Plant, *J. Am. Soc. Agron.*, **30**:725, 1938.

²⁰ Couch, J. F.: Poisoning of Livestock by Plants that Produce Hydrocyanic Acid, *U. S. Dept. Agric. Leaflet* No. **88**, 1934.

²¹ Pijoan, M.: Cyanide Poisoning from Chokecherry Seed, *Am. J. Med. Sc.*, **204**:550, 1942.

²² Warburg, O.: *Über die antikatalytische Wirkung der Blausäure*, Julius Springer, Berlin, 120, 1928.

²³ Henderson, Y. and Haggard, H. W.: *Noxious Gases and the Principles of Respiration Influencing Their Action*, Reinhold Publishing Corporation, New York (2d ed.), 172, 1943.

²⁴ Chen, K. K.; Rose, C. L., and Clowes, G. H. A.: Cyanide Poisoning and Its Treatment, *J. Am. Pharm. A.*, **24**:625, 1935.

²⁵ Gettler, A. O., and Baine, J. O.: The Toxicology of Cyanide, *Am. J. Med. Sc.*, **195**:182, 1938.

²⁶ Chen, K. K.; Rose, C. L., and Clowes, G. H. A.: Comparative Values of Several Antidotes in Cyanide Poisoning, *Am. J. Med. Sc.*, **188**:767, 1934.

²⁷ Hug, E.: Acción del nitrito de sodio y del hiposulfito de sodio en el tratamiento de la intoxicación provocada por el cianuro de potasio en el conejo, *Rev. Soc. Argent. de biol.*, **9**:91, 1933.

²⁸ Hug, E.: Asociación nitrito-hiposulfito de sodio en el tratamiento de la intoxicación cianhídrica en el perro, *Rev. Soc. Argent. de biol.*, **9**:197, 1933.

²⁹ Hug, E.: Superioridad de la asociación nitrito-hiposulfito de sodio en el tratamiento de la intoxicación cianhídrica, *Prensa méd. Argent.*, **20**:1527, 1933.

³⁰ Hug, E.: Treatment of Hydrocyanic Acid Poisoning, *J.A.M.A.*, **102**:552, 1934.

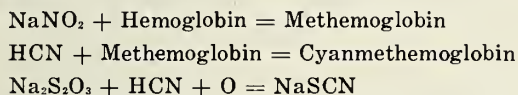
³¹ Buzzo, A. and Carratala, R. E.: El nitrito de sodio y el hiposulfito de sodio como antidotos de la intoxicación determinada por el cianuro de potasio, *Semana méd.*, **40**:1224 (I), 1933.

³² Buzzo, A. and Carratala, R. E.: Nueva contribución al estudio de la acción del nitrito de sodio y del hiposulfito de sodio en la intoxicación determinada por el cianuro de potasio, *Semana méd.*, **40**:1966 (I), 1933.

³³ Chen, K. K.; Rose, C. L., and Clowes, G. H. A.: Methylene Blue, Nitrites, and Sodium Thiosulphate against Cyanide Poisoning, *Proc. Soc. Exper. Biol. and Med.*, **31**:250, 1933.

sodium nitrite and sodium thiosulfate is the best therapy against cyanide and hydrocyanic acid poisoning. The two substances intravenously injected, one after the other, namely, the nitrite followed by the thiosulfate, are capable of detoxifying approximately twenty lethal doses of sodium cyanide in dogs, and are effective even after respiration has stopped. As long as the heart is still beating, the chances of recovery by this method of treatment are very good. Since dogs are more susceptible to the poison than man,³⁷ these observations are especially significant. When sodium nitrite is used alone, about four lethal doses of the cyanide are detoxified. Sodium thiosulfate, when injected alone, nullifies about three lethal doses of the cyanide. Thus, there is not only a summation but a definite potentiation of action when the nitrite and the thiosulfate are administered together.

The mode of action is probably as follows: sodium nitrite reacts with hemoglobin to form methemoglobin. The latter removes cyanide ions from various tissues and couples with them to become cyanmethemoglobin, which has a relatively low toxicity. The function of sodium thiosulfate is to convert cyanide to thiocyanate, probably by an enzyme known as rhodanase.³⁸ The combined mechanism may thus be expressed in a chemical manner.



Sodium thiosulfate, commonly called "hypo" in photography, has a very low toxicity. Dogs can tolerate as much as 3 g. per Kg. by vein.²⁶ The antidotal action of sodium thiosulfate in cyanide poisoning was first demonstrated by Lang,³⁹ and his work was confirmed by Hunt⁴⁰ and many others. Although the efficacy of the thiosulfate therapy alone is limited to detoxification of no more than three lethal doses of cyanide, favorable clinical reports have been published.^{41, 42, 43, 44.}

³⁴ Hanzlik, P. J. and Richardson, A. P.: Cyanide Antidotes, *J.A.M.A.*, **102**:1740, 1934.

³⁵ Etteldorf, J. N.: The Treatment of Gaseous Hydrocyanic Acid Poisoning by Sodium Thiosulfate and Sodium Nitrite Combination, *J. Pharmacol. and Exper. Therap.*, **66**:125, 1939.

³⁶ Mukerji, B.: Cyanide Poisoning and Its Treatment with Antidotes, *Indian M. Gaz.*, **72**:353, 1937.

³⁷ Barcroft, J.: The Toxicity of Atmospheres Containing Hydrocyanic Acid Gas, *J. Hyg.*, **31**:1, 1931.

³⁸ Lang, K.: Die Rhodanbildung im Tierkörper, *Biochem. Ztschr.*, **259**:243, 1932.

³⁹ Lang, S.: Über Entgiftung der Blausäure, *Arch. f. exper. Path. u. Pharmacol.*, **36**:75, 1895.

⁴⁰ Hunt, R.: Zur Kenntniss der Toxikologie einiger Nitrile und deren Antidote, *Arch. internat. de pharmacodyn. et de therap.*, **12**:447, 1904.

⁴¹ Lassaga, A.: Tratamiento de la intoxicación cianuro-potásica por el hiposulfito de soda, *Semana méd.*, **34**:443, (I) 1927.

⁴² Buzzo, A.: Tratamiento de la intoxicación por cianuro de potasio con el hipo-sulfito-sódico, *Rev. de especialidad*, **2**:869, 1927.

FIGURE III



45, 46 For some time its use, by intravenous injection, has also been advocated for the treatment of poisoning by heavy metals.⁴⁷

That sodium nitrite by itself is an effective agent in combating cyanide poisoning was first shown by Mladoveanu and Gheorghiu⁴⁸ in dogs. Subsequent workers^{49, 50, 51, 52, 53} elucidated its mode of action,

⁴⁵ Piqué, J. A.: Un caso de intoxicación por cianuro de potasio tratado por hiposulfito de sodio intracardíaco, *Semana méd.*, **35**:308, (I) 1928.

⁴⁶ Zimman, J.: Otro caso de intoxicación por cianuro de potasio tratado por hiposulfito de sodio intracardíaco, *Semana méd.*, **35**:1235, (I) 1928.

⁴⁷ Feyerabend, K.: Zur Therapie der Cyankaliumvergiftung, *Klin. Wchnschr.*, **7**:1351, 1928.

⁴⁸ Coutinho, A.: Radical cianico e hiposulfito, *Rev. med. de Pernambuco*, **8**:113, 1938.

⁴⁹ McBride, W. L., and Dennie, C. C.: Treatment of Arspenamin Dermatitis and Certain Other Metallic Poisonings, *Arch. Dermat. and Syph.*, **7**:63, 1923.

⁵⁰ Mladoveanu, C. and Gheorghiu, P.: Le nitrite de soude comme antidote de l'empoisonnement experimental par le cyanure de potassium, *Compt. rend. Soc. de biol.*, **102**:164, 1929.

⁵¹ Hug, E.: La intoxicación por el ácido clanhídrico. La acción antidótica del azul de metileno, sulfuro de sodio y nitrito de sodio, *Rev. Soc. Argent. de biol.*, **8**:270, 1932.

⁵² Moller, K. O.: Die Bedeutung der Methämoglobinbildung bei der Entgiftung von Blausäure mittels Methylenblau und Natriumnitrit, *Skandinav. Arch. f. Physiol.*, **73**:267, 1936.

⁵³ Mladoveanu, C.; Vasilco, O., and Gheorghiu, P.: La méthémoglobine dans les intoxications par le cyanure de potassium, *Bull. Acad. de méd. de Roumanie*, **2**:527, 1937.

⁵⁴ Brooks, M. M.: Hemoglobin-Methemoglobin and KCN, *Proc. Soc. Exper. Biol. and Med.*, **40**:108, 1939.

⁵⁵ Smith, R. G.; Mukerji, B., and Seabury, J. H.: Thiocyanate Formation in Cyanide Poisoning as Affected by Methylene Blue and Sodium Nitrite, *J. Pharmacol. and Exper. Therap.*, **68**:351, 1940.

that is, the formation of methemoglobin and then cyanmethemoglobin. A human case of cyanide poisoning successfully treated with sodium nitrite alone was reported by Mota.⁵⁴ Although sodium nitrite has been employed in medicine for a long time as a depressor substance, its high toxicity, particularly by intravenous injection, must be kept in mind. In dogs, the median lethal dose by vein lies in the neighborhood of 45 mg. per Kg.²⁶ It is therefore suggested that in man, unless the quantity of the poison absorbed is exceptionally large, the amount of the nitrite injected should not exceed the doses specified below.

Another nitrite, namely amyl nitrite, by inhalation has the same detoxifying value as sodium nitrite by intravenous injection. It is mentioned here because it is the oldest antidote for cyanide poisoning, and is a preliminary adjuvant of the present treatment. Pedigo (Figure III),⁵⁵ the discoverer, described its antagonism against hydrocyanic acid in 1888 (Figure IV). His work, however, was not widely known. It was called to our attention by Dr. Pedigo himself at the time of our experimentation.²⁶ The validity of his results was firmly established by recent investigators.^{56, 57}

A SUGGESTED PROCEDURE FOR ACTUAL TREATMENT

Cyanide poisoning is rapidly fatal. The patient seldom survives many hours. On the other hand, no case can be considered hopeless unless the heart beat has completely stopped. The prevention of death demands a quick diagnosis and the prompt use of specific antidotes. No valuable time can be lost. Even though the diagnosis is doubtful, the recommended therapy should be immediately instituted. For the best results the physician should be acquainted beforehand with the following steps:

I. Instruct an assistant how to break, one at a time, pearls of amyl nitrite in a handkerchief and hold the latter over the victim's nose for fifteen to thirty seconds per minute. At the same time the physician quickly loads his syringes, one with a 3 per cent solution of sodium nitrite, and the other with a 25 per cent solution of sodium thiosulfate.

II. Stop administration of amyl nitrite and inject intravenously 0.3 g. (10 cc. of a 3 per cent solution) of sodium nitrite at the rate of 2.5 to 5.0 cc. per minute.

III. Inject by the same needle and vein, or by a larger needle and a new vein, 12.5 g. (50 cc. of a 25 per cent solution) of sodium thiosulfate.

⁵⁴ Mota, M. M.: Sobre un caso de intoxicación por cianuro de potasio tratado con éxito por el nitrito de sodio, *Rev. méd. del Rosario*, 23:674, 1933.

⁵⁵ Pedigo, L. G.: Antagonism between Amyl Nitrite and Prussic Acid, *Trans. Med. Soc. Va.*, 19:124, 1888.

⁵⁶ Wendel, W. B.: The Mechanism of the Action of Methylene Blue and Sodium Nitrite in Cyanide Poisoning, *J. Biol. Chem.*, 100: Proc. c, 1933.

⁵⁷ Chen, K. K.; Rose, C. L., and Clowes, G. H. A.: Amyl Nitrite and Cyanide Poisoning, *J.A.M.A.*, 100:1920, 1933.

FIGURE IV

Reprinted from the Transactions of the Medical Society of Virginia, held at Norfolk, 1888.

Antagonism between Amyl Nitrite and Prussic Acid.

By LEWIS G. PEDIGO, M. D., Roanoke, Virginia.

In the May number of the *Virginia Medical Monthly*, I reviewed a case of atropia poisoning which had occurred in the person of a man prominent in the judiciary of our State, and in which that valuable life was saved by the timely and assiduous use of amyl nitrite. In concluding that article I recorded the suggestion that the remedy used would prove to be a physiological antidote to certain other cardiac depressants, such as veratrum viride, aconite, gelseminum and especially prussic acid. Since that time I have continued the series of experiments upon which that opinion was based, and as a result, the opinion has been entirely borne out.

The patient should be watched for at least twenty-four to forty-eight hours. If signs of poisoning reappear, injection of both sodium nitrite and sodium thiosulfate should be repeated, but each in one-half of the dose. Even if the patient looks perfectly well, the medication may be given for prophylactic purposes two hours after the first injections.

If respiration has ceased but the pulse is palpable, artificial respiration according to Schafer's manual method or the simple procedures recommended by Waters⁵⁸ should be applied at once. The purpose is not to revive the respiration *per se*, but to keep the heart beating. The handkerchief containing amyl nitrite should be laid over the patient's nose, for it may hasten the resumption of respiratory movements. When signs of breathing appear, injection of the above solutions should be promptly made.

If the poison is taken by mouth, gastric lavage should be carried out, preferably by a third person—a physician or a nurse.

As a matter of preparedness for the successful treatment of cyanide poisoning, a kit composed of the following articles may be installed in emergency cabinets, ambulances, and chemical laboratories, or carried at all times with fumigation equipment:

12 pearls of amyl nitrite; 2 ampules of sodium nitrite, 0.3 g. in 10 cc. of water, sterilized; 2 ampules of sodium thiosulfate, 12.5 g. in 50 cc. of

⁵⁸ Waters, R. M.: Simple Methods for Performing Artificial Respiration, *J.A.M.A.*, 123:559, 1943.

water, sterilized; 1 sterile syringe, 10 cc. size, with a 22-gauge needle; 1 sterile syringe, 50 cc. size, with an 18-gauge needle; 1 file; and 1 stomach tube (not necessary for fumigators).

By the addition of certain preservatives, the above solutions remain stable in ampules for several years. For example, in this laboratory a lot of ampules kept at room temperature for eight years was found to be of full strength by chemical assays, although slight cloudiness appeared in the ampules of sodium thiosulfate. It is, however, possible to make ampules of dry crystals of each product, which can be dissolved in sterile distilled water at the time of injection. If the ampules are not available, the nitrite and the thiosulfate may be separately weighed out from bottles into beakers and dissolved in sterile water, or, if that is not available, in tap water. These solutions may then be promptly injected. The urgent necessity of speed in the treatment of cyanide poisoning justifies the omission of sterilization. Furthermore, from the experience of animal experimentation, infection very rarely occurs following intravenous injection even though the drug solutions are not sterilized. If injection is made intramuscularly or subcutaneously, the non-sterilized solutions more frequently cause abscess formation.

The same combination, that is, sodium nitrite and sodium thiosulfate, has been advocated for sheep and cattle which have been poisoned by eating cyanogenetic plants.^{59, 60, 61}

RESULTS TO DATE

Clinical trials with the present method of treatment fully substantiate the observations in animals. They are reviewed and described as follows:

Viana, Cagnoli, and Cendan,⁶² of South America, reported two cases successfully treated with the nitrite-thiosulfate combination. The first case was that of a young woman who took 5 g. of potassium cyanide with suicidal intent. Ten minutes later she was found in coma with stertorous respiration. Treatment consisted of the inhalation of 1 ampule of amyl nitrite, and intravenous injection of 20 cc. of a 2 per cent solution of sodium nitrate, and 20 cc. of a 30 per cent solution of sodium thiosulfate. The medication was repeated in two hours until a total of 1.5 g. of sodium nitrite and 18 g. of sodium thiosulfate had been administered. Although the patient became markedly cyanotic, because of an overdose of the nitrite, she completely recovered.

The second case was that of another woman who ingested 2 g. of potassium cyanide to commit suicide. In fifteen minutes she was discovered in coma, and was treated with 1 ampule of amyl nitrite and a total amount of 0.75 g. of sodium nitrite and 12 g. of sodium thiosulfate. She also recovered.

Hug⁶³ quoted a case attended by Dr. R. Hertz, of Rosario, Argentina. A woman had tried to commit suicide with cyanide (quantity unknown). She was in a comatose condition, but she reacted very rapidly to sodium nitrite and sodium thiosulfate.

In 1935 Dr. G. F. Kempf, Indianapolis City Hospital, treated a woman, aged thirty-four, who swallowed a large but undetermined quantity of potassium cyanide for the purpose of ending her life. One hour and forty minutes later she was admitted to the hospital. Her respiration was very shallow and rapid, radial pulse imperceptible, heart sounds distant and weak, and reflexes absent. Administration of amyl nitrite (by inhalation), 0.3 g. of sodium nitrite, and 20 g. of sodium thiosulfate brought complete recovery.

Ingegno and Franco⁶⁴ successfully treated two cases of accidental poisoning. The first subject, a laborer twenty years of age, was helping in the removal of small trucks loaded with cotton from a fumigating tank. He felt a constriction in his neck which made it impossible for him to breathe, and then lost consciousness. He was discovered by his fellow-workers and brought to the hospital accident room. On examination he was found unconscious, the color of his skin was slaty, and the respiration was deep and somewhat accelerated. There were bursts of violence, requiring restraint. About two and one-half hours after he lost consciousness, amyl nitrite was given by inhalation, followed by intravenous injection of 0.3 g. of sodium nitrite and 25 g. of sodium thiosulfate. The medication in one-half of the dosage was repeated in one hour and forty-five minutes. Complete recovery occurred. The second patient was a commercial artist, aged twenty-five. He accidentally swallowed a mouthful of a 6 per cent solution of potassium cyanide. He promptly became weak, vomited profusely, experienced difficulty in breathing, and lost consciousness. He was moved to the hospital. Examination revealed him to be unconscious, of dusky hue, with labored breathing, rapid pulse and tremors. The stomach was washed out with a solution of hydrogen peroxide. Two hours and twenty minutes after the ingestion of the poison, amyl nitrite, 0.3 g. of sodium nitrite, and 12.5 g. of sodium thiosulfate were given in order. Two hours later the same dose of sodium nitrite and sodium thiosulfate was repeated. He recovered completely.

⁵⁹ Bunyea, H.; Couch, J. F., and Clawson, A. B.: Pharmacology—The Nitrite-Thiosulphate Combination as a Remedy for Cyanide Poisoning in Sheep, *J. Wash. Acad. Sci.*, **24**:528, 1934.

⁶⁰ Clawson, A. B.; Couch, J. F., and Bunyea, H.: The Toxicity of Sodium Cyanide and the Efficiency of the Nitrite-Thiosulfate as a Remedy for Poisoned Animals, *J. Wash. Acad. Sci.*, **25**:357, 1935.

⁶¹ Hadley, F. B., and Kozelka, F. L.: Antidotes for Hydrocyanic Acid Poisoning, *Vet. Med.*, **30**:79, 1935.

⁶² Viana, C.; Cagnoli, H., and Cendan, J.: L'action du nitrite de sodium dans l'intoxication par les cyanures, *Compt. rend. Soc. de biol.*, **115**:1649, 1934.

⁶³ Hug, E.: *Tratamientos de la Intoxicación Cianhidrica*, El Ateneo, Buenos Aires, 124, 1934.

⁶⁴ Ingegno, A. P., and Franco, S.: Successful Treatment of Two Cases with Intravenous Sodium Nitrite and Sodium Thiosulfate, *Indust. Med.*, **6**:573, 1937.

Dr. J. M. Carlisle, of Rahway, New Jersey, treated six cases of cyanide poisoning by the above method in the course of a year with one fatality. No details were available, but he stated that in the fatal case the patient was extremely cyanotic, in fact moribund, at the time when medical aid was instituted.

Williams⁶⁵ reported a case of a fumigator who was overcome and fell in the building where he was spraying liquid hydrocyanic acid, although he wore a gas mask. He was discovered by other fumigators and brought out into the open air. He was unconscious, not breathing, and appeared to be dead. Artificial respiration was instituted and maintained for one and one-half hours, during which time the patient was taken to the hospital. Breathing, of Cheyne-Stokes type, was then noted. He was still in deep coma and markedly cyanotic. His pulse was faint but palpable; heart sounds were barely audible; and the blood pressure in mm. Hg was 90 systolic, 58 diastolic. At the hospital 20 cc. of a solution containing 0.6 g. of sodium nitrite, followed immediately by 100 cc. of a solution containing 50 g. of sodium thiosulfate, were promptly injected intravenously. There was immediate improvement, as evidenced by return of normal color and rise of blood pressure to 102 systolic, 66 diastolic. Before discharge, the man developed convulsions and maniacal episodes which were not attributable to the antidotes.

In 1940, Dr. Max Greenberg, of Linden, New Jersey, communicated to us a case history which merits recording. "The patient was actually snowed under in a heap of calcium cyanide which came out of a hopper in a gush because of an unnoticed obstruction below it. He crawled out of this heap and walked a distance of twenty-five feet. Then he became unconscious. His fellow workers picked him up and brought him to the first-aid room of the plant." After a lapse of twenty minutes, the man was totally unconscious; respiration was imperceptible; and radial pulse almost absent although the apical beat was audible—faint and rapid, 140-160 per minute. Artificial respiration was administered. After two applications of amyl nitrite, the radial pulse became palpable but faded out in three or four minutes. A 10 per cent solution of sodium nitrite (volume not recorded) was then injected intravenously. In less than three minutes, while the needle was still in the vein, the patient began to breathe and move his head. The radial pulse was 120-130 per minute. He looked up, mumbled a few inarticulate words, and showed signs of recognizing people. In several minutes, however, he again became unconscious and his respiration became feeble. It was soon discovered that there were crusts of calcium cyanide in the axillae and along the legs. These were removed by washing with water, and at the same time sodium thiosulfate (quantity not

specified) was administered intravenously. A few minutes later the patient was conscious and talked rationally—recovering completely.

In 1941, Dr. W. Burgess Boone, of Tulsa, Oklahoma, studied a case of cyanide poisoning. The patient was a man fifty-six years of age who attempted suicide. He was found unconscious in bed, and was brought to the hospital thirty minutes later. A snuff can filled with a dark powder (later found to be an insecticide) was discovered on the window sill beside the bed. The powder liberated hydrocyanic acid when dampened. This was the source of poisoning, as confessed by the patient later. On the way to the hospital he vomited and had mild convulsions when moved or otherwise stimulated, and some urinary incontinence. Examination at the hospital showed that his skin had a reddish-cyanotic tinge, his respiration was shallow, and his pulse thready. There was a suggestion of a bitter almond odor to his breath. Gastric lavage was instituted immediately. Since sodium nitrite was not available at the hospital, reliance was placed on amyl nitrite inhalation. A total of sixteen pearls was used. Meanwhile, a 10 per cent solution of sodium thiosulfate was injected intravenously, amounting to 10 g. in all. Fifteen minutes following the injection he began to show signs of returning consciousness. He was discharged the next day, fully recovered.

Thus, to date, there have been at least fifteen cases treated with the nitrite-thiosulfate therapy. Fourteen of the patients completely recovered, while the single failure might have resulted from the fact that poisoning was too far advanced when the antidotes were administered or that too large an amount of cyanide had been absorbed. In the series of cases just reviewed, the majority would probably have ended in death had treatment not been instituted promptly. Those who have studied the antidotes either experimentally or clinically cannot but be impressed by the rapidity of response and the recovery of the poisoned subjects. Success is forthcoming if the physician remembers that quick diagnosis and immediate treatment are imperative. It cannot be overemphasized that in order to obtain the best results, amyl nitrite, sodium nitrite, sodium thiosulfate, and other accessories mentioned above should be readily available in places where a physician may be called upon to treat cases of cyanide poisoning.

SUMMARY

1. Various sources of poisoning by cyanide and hydrocyanic acid, and their mortality statistics, have been discussed and enumerated.
2. The new method of treatment employing amyl nitrite as the preliminary adjuvant, and sodium nitrite and sodium thiosulfate by intravenous injection, has been described in detail.
3. A total of fifteen cases, six of which are already recorded in literature, have been treated by the new procedure. Fourteen of these patients completely recovered.

⁶⁵ Williams, C. L.: An Unusual Case of Cyanide Poisoning during Fumigation, *Pub. Health Rep.*, 53:2094, 1938.

CLINICAL SYMPTOMS OF TYPHOID FEVER IN NINE CASES

VIRGIL C. MILLER, M.D.

AKRON

During the recent epidemic of typhoid fever I had nine cases under observation. All are now symptom-free and have had two successive negative stool cultures. Their ages were 3, 6, 8, 10, 18, 21, 26, 29 and 34 years. The nine cases represented six families, and in no family were all members infected. Generally speaking, the older the individual the more severe were the symptoms. All but one case were managed in the home. It was impossible to make daily visits to each patient, so detailed clinical study with frequent laboratory procedures could not be made.

All cases were in their second or third week of illness when I first saw them, so their prodromal symptoms could be obtained only by histories. The symptoms varied slightly from the usual textbook picture, although they followed the general pattern. All cases showed positive Widal 1-320 dilution, and three cases showed positive 1-640 dilution. All showed positive stool cultures. One case showed positive agglutination reaction for brucellosis, 1-320 dilution. Agglutination tests for brucellosis in the remaining eight were negative.

The individual showing positive typhoid and brucellosis reaction was extremely ill and required hospital management. The duration of his illness was more prolonged and symptoms more acute. I have reason to suspect that he had during the past year undergone the acute phase of brucellosis, which he had mistaken as "flu," and as a result of his weakened condition his reaction to typhoid was extremely severe. The individual being a farmer had his dairy herd tested for undulant fever, and more than half of the cows were positive. He informed me that his best producers and healthiest-appearing cattle were the ones infected. This, incidentally, substantiates materially some of the very brilliant deductions recently made by Dr. Dan Urschel, of Mentone, in his articles on "brucellosis," published in *THE JOURNAL*.

In my cases of typhoid, *bronchitis* was rare, only one of nine cases showing marked respiratory symptoms of any nature, and this was confined to the prodromal period and could have been a co-existing coryza.

Nosebleed: Four cases had recurrent nosebleed as an early symptom, and all but two had it sometime during the course of the disease.

Fever: All cases were of septic nature, the temperature being on a plateau during the second, third, and part of the fourth weeks. The average range was 101 to 104 degrees F, reaching a peak on the average of three times in twenty-four hours. The most severe case ran a temperature of 106 degrees F on four occasions during the third week of his illness.

Pulse: The pulse was not characterized by its slow ratio in reference to fever height, except when the temperature reached its highest peak. It had a definite dirotic nature when the fever was high. The blood pressure was low in all cases.

Roseola: Four of nine cases showed rose-colored spots in the second week. These were confined to the chest and abdomen, more prominent on the chest. All of the spots observed were in adults. They appeared as pale rust-colored macules 1-5 mm. in diameter.

Pallor: All cases developed a definite pallor, especially of the face, early in the disease. It had the appearance of a pallor caused by acute blood loss, although there was bowel hemorrhage in but one case, and this was moderate.

Herpes: No herpes was present, although the lips were dry and cracked in all cases.

Perspiration: This was a constant symptom from the prodromal period to convalescence. It always followed a chill or chilly sensation, and it seemed to be extremely profuse considering the preceding temperature. There was no diagnostic odor to the perspiration.

Distention: All cases were moderately distended, but none complained of much discomfort from it. All were promptly relieved by enemas.

Spleen engorgement: This was constant and persisted throughout the course of the disease. Eight of the nine cases showed a tendency toward constipation, and one had diarrhea early with later bowel hemorrhage. Dull headache was present in six cases; severe headache in three. The average weight loss was 5 per cent of the normal weight. No severe complications were encountered.

Treatment: Sulfathiazole was tried and soon abandoned as useless and probably detrimental because it disturbed an already waning appetite. Good nursing care plus a high-caloric diet were the most essential measures. Vitamin B complex in large doses, orally, seemed to stimulate the appetite to some extent and also seemed to benefit the individuals from a neurological standpoint. Sedatives were used as needed to induce sleep.

No particular summary or conclusion is necessary, except to stress the fact that there is a rather long prodromal period in most cases. During this time headache, malaise, nosebleed, fever, and perspiration are common. Also, during this period the disease may be spread in various ways. I feel that there is still danger of a typhoid outbreak with the approaching warm weather.

The nursing service furnished by the Indiana State Board of Health was extremely helpful and sincerely appreciated by the patients as well as by myself.

MEDICAL RECORDS AND RECORD KEEPING IN INDUSTRY*

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Medical records are a "must" item in the armamentarium of the industrial physician. However, depending on his individual point of view, they may consist of anything from scribbled notes on his cuffs to the most elaborate record system known to modern office procedures, but the fact remains that they are essential. We all make records and we all keep records; so to say the least, this is anything but a new subject. In spite of our familiarity with it, this is a timely subject and one that has increasing potential for giving us greater assistance in the performance of our respective duties. I prefer to discuss some of the basic principles essential in the making and the keeping of medical records, and also some of the benefits to be derived from their tabulation and study. It is in this latter respect that we have much to gain from our records.

It is essential to remember that records are not an end in themselves, but a means to an end. We would do well to reduce to records the many new experiences confronting us today, for we truly have opportunities heretofore only dreamed. Our records of today may prove to be of inestimable value in the solution of tomorrow's problems.

The medical department which can merely quote totals, so many examinations and so many dispensary treatments, is only stating the title of the book. The real plot, the true story, can only be understood by the tabulation and study of those records.

To sense the need for industrial medical records, it is essential to understand the role in industry of the modern industrial physician. Only then can we know what should be recorded. The industrial physician of today is emerging (I wish we could say that he had emerged) from the era in which the care of the injured employee was his only objective. The industrial physician's responsibilities are all inclusive today; namely, care of the injured, employee health, plant health, sanitation, nutrition, rehabilitation, absenteeism, and numerous others. In accepting these responsibilities it is essential that he back himself with records adequate to defend his decisions of today and to plan for the future.

Records should give the physician an opportunity to record his daily experiences. They should assist him in interpreting his findings and observations. They should help him solve his current problems. Through these records he may catch a

gleam of the future. They should have their rightful place in the constant advance of medicine.

For obvious reasons the record system should be just as simple and as easily understood as is practical in order to obtain the desired results. Forms, copies, cards, et cetera, will vary with the specific job and the personality of the boss; but even these are only justifiable as long as they serve a definite purpose. Keeping records just for the sake of keeping them is an outstanding example of misdirected effort. Too often we spend valuable time in obtaining records, only to lock them in steel cabinets, with little or no thought of ever liberating them again. If we accept Webster's definition of records as "that which is written to perpetuate a knowledge," I believe we will get the idea that records are anything but dead. They are alive. They should be used. Their value increases in direct proportion to the use made of them. There is a need for better records to be made, but there is a greater need for the records we are now making to be used more effectively.

The fundamental unit of the record system is the record on the individual employee. From the moment he steps into your plant until the day he is terminated from employment, he is your responsibility and your record of him must be complete. It should contain the pre-employment examination (including any recommendations relative to job placement), all subsequent examinations, and a chronological record of every visit to the dispensary. The record should also include all correspondence regarding him, such as notes from the family physician, memos from supervision, and data from the safety and personnel departments. In other words, it should include anything and everything that has come to your attention regarding the individual. The complete record will then enable you to answer most questions that might arise regarding him, whether the inquiry pertains to his health, safety performance, injury record, general attitude, absenteeism performance, or compensation claims; and it will also enable you to make a definite recommendation regarding his physical fitness for increased job responsibilities.

In the past, one of the strongest arguments for good records was based on the possibility that at some future time a legal entanglement might arise. That point is well taken, but I believe it is grossly exaggerated in importance. The housewife who keeps her house in order at all times need not be unduly perturbed by the unexpected arrival of company. Furthermore, those living in that home will have the daily benefit of her industry and ambition. A summons to court should not be cause for undue confusion, nor should it necessi-

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association, at Indianapolis, on April 19, 1944.

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tate a last-minute scurry to fill in the gaps of the incomplete record. All the facts should have been recorded while the case was active.

Suffice it to say that in the modern conception of industrial medical records, the possibility of future legal action is only one of the many good reasons for their creation and care. Other justifiable reasons would include the individual himself, the industrial physician, management, the safety engineer, other employers, the individual's family, the family physician, and the public health department. This record then, to be of maximum usefulness, must not only protect the individual's health *per se*, but also must be capable of sponsoring his best interests in numerous other ways. This broadened horizon of usefulness of the complete record is in keeping with the modern conception of the type of service the industrial physician should be able to render today.

Information on the individual is derived chiefly from two sources; namely, the examination records and the dispensary records. The examination records constitute a major portion of the individual's complete medical record, and in many instances are the "yardstick" by which his industrial usefulness is determined. Some of the specific types of examinations would include: pre-employment, annual, transfer, special, and termination. Regardless of the type of examination, the physician will gain much if he takes a few additional moments to make his patient feel at ease and to gain his confidence before actually starting the examination. To derive the maximum benefit from these examinations, there are two essential factors: first, make the examination complete; and second, record the findings in detail.

Dispensary records must be complete and should include a chronological listing of every dispensary visit, stating the diagnosis, treatment, and result. It should also contain full information regarding all absences due to illness. Whereas the examination contacts are relatively formal, the dispensary contacts are exceedingly informal and the average employee feels that here he can truly "let his hair down." The alert nurse or physician in the dispensary can obtain much valuable information which may prove to be of importance, not only to the individual but in many cases to the plant as a whole. The dispensary can truly be the "cross roads" of the plant.

Thus far we have concerned ourselves only with the individual's medical record and have attempted to show how this record aids in protecting his best interests. What about our obligation to the aggregate of our employees, or the plant as a whole? The individual record will do little or nothing to aid their cause. It now becomes essential to pool all their records, and, by tabulating and comparing, note the facts and investigate the trends. It is impossible to spot the unusual incidents or toxic exposures from the individual record, nor can you afford to sit in your office and wait for sufficient individual cases to actually develop be-

fore your suspicion is aroused. The record system must be so sensitive that it will detect the unusual before the unusual has actually occurred. By tabulating and comparing records the slightest deviation from the normal can be detected.

Group record study is essential. Although our employees are individual, they are not absolutely independent, isolated entities, but are interrelated and affected *en masse*. Hours of work, shift schedules, dust, fumes, and toxic exposure do have a group reaction. It is through group record study that trends can be first detected, and thus the best interests of both employee and employer can best be served. Also, the industrial physician has much to learn through this medium.

The analysis of group examination records will indicate the types and frequency of certain defects and incidence rates of certain diseases, such as tuberculosis, lues, and others. It provides a means for the early detection of chemical intoxication. Comparative studies can also be made between the sexes.

The tabulation and study of group dispensary records will provide such information as the number of visits, types of injuries, frequency of condition, seasonal trends, and occupational trends. It also provides an opportunity to evaluate the therapeutic measures employed. Based on time and cost studies, the physician can attempt to alter existing procedures in an effort to improve the operating efficiency of the department. By reviewing the dispensary absentee records the physician can keep abreast with the current trends in the community and carry on investigations regarding the possibility of the occupation being an etiological factor of disease.

So much for the "why" of complete medical records on the individual, and the tabulation and study of group records. How are they actually obtained? Only by the active cooperation on the part of all concerned, which includes the training of the recorder and the strict adherence to a standard procedure. In discussing this phase of the subject, certain non-medical details will be mentioned which have a direct bearing on the overall functioning of the medical department. As was previously said, we are concerned not only with medical treatment but also are called upon to render service in many ways. Thus the records we make should be capable of aiding us in as many ways as possible.

Just a few words about the actual making of records. Be certain that your record tells a definite story. We are all acquainted with the individual who has the habit of doing a lot of talking but who in reality says very little. The same is true of records. Many of us have been guilty of making notations and, upon completion, were amazed to find that all we had written was so many words. We had omitted the real facts. We had written so rapidly that we failed to make our notes complete. How many times have you

read someone else's report, only to be confronted with half a dozen questions that should have been answered? Thus, it is essential to train the writer to think before he writes. One can be trained to be just as systematic in writing records as he is in performing an examination or laboratory test. Standardize the write-up as much as is practical; this will aid in obtaining all the cardinal facts. Don't leave the reader to guess or assume. Tell him!

The examination record, regardless of the type of examination, is completed in detail and reviewed by the physician. Proper disposition is made of the case, and the necessary follow-up is instituted. The completed forms are placed in the individual's medical folder. All correspondence pertaining to the individual is also placed in this medical folder.

The individual's dispensary record remains in the medical folder at all times, except during the times that he is actually receiving treatment for any current condition or is absent from the plant due to illness. During these times the dispensary record is filed in the "Active Dispensary File" to insure a thorough follow-up of the case. The dispensary record remains in this file until the case is closed, which is indicated by the fact that no further treatment is deemed necessary or that the individual has returned to work. You cannot rely on your memory to follow your active cases. Your record system must be so designed that it is capable of following them for you, and thus insure that they report for treatment in accordance with your instructions.

Having obtained the individual examination record and the dispensary record, we are now ready to tabulate. Many of us do not have the opportunity of using the punch card equipment for tabulating purposes, nor is this equipment absolutely essential for the average plant. Practical and useful tabulations are possible by recording the individual records on a "Master Chart." This chart is prepared in accordance with the needs of the specific plant. In addition to the standard entries, new ones can be added from time to time until the status of the new entry has been evaluated. To accomplish this tabulation there are just two essential factors: first, every medical record (both examination and dispensary) must pass over one central tabulating desk; and second, that desk must be staffed at all times with a well-trained, competent, reliable clerk. The flow of records over this desk must be continuous; otherwise, this purely clerical procedure becomes a bottleneck and can interfere with the routine medical work.

The Master Chart in Figure I provides an opportunity for the tabulation of the daily volume of work performed by every division of the medical department. It enables the director, at a glance, to know exactly "what is going on." It can also be used as the basis for the monthly statistical report for the entire department.

FIGURE I
DAILY TABULATION

1944 February	Day of the Month														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Plant—															
New															
Retreat															
Total															
Welfare—															
New															
Retreat															
Home															
Return															
Total															
Total Dispensary															
Examinations—															
Employment															
Transfer															
Termination															
Annual															
Special															
Total Examinations															
Total Hospital															
X-ray—															
Chest															
Miscellaneous															
Total															
Blood Counts															
Urine															
Misc. Lab. Tests															
Total Lab. Work															
Serology—															
New															
Retest															
Total															
Physiotherapy															
Ward Cases															
Insurance Cases															
Consultations															
General Hospital															
Ambulance Runs															
Modified Work															
Home Visits															

The dispensary records are tabulated under one of the following categories: New Plant, Retreat Plant, New Welfare, Retreat Welfare, Sent Home, and Return to Work. It also shows the ratio in the volume of Compensation (Plant Cases), as compared with the Welfare Cases.

Examination records are tabulated according to type, sex, job, defects noted, and disposition of the case.

The volume and type of work performed by all other divisions is also tabulated.

A daily tabulation of the New Plant Injuries is compiled for the safety engineer, thus enabling him to maintain close contact with the plant accidents and to take steps to correct the safety hazards (Figure I-B).

Although all phases of the medical work are tabulated, for this discussion we will limit our remarks to the tabulation of the dispensary records, and show how this procedure permits a study of these records.

FIGURE I-b
DAILY INJURY LOG

NEW OCCUPATIONAL INJURIES					Date: 7:30 A.M. 4/20/44 to 7:30 A.M. 4/21/44	
Arrived in Hosp.	Department	Name	No.	Nature of Injury	Treated by	Accident Location
8:20 A.M.	B	Doe, John	2336	Acid splash, rt. eye (SS)	Dr. Jones	Bldg. No. 109

Following the preliminary tabulation of all the dispensary cases, every case previously tabulated as New Plant (Compensation) and New Welfare is now tabulated on a Master Chart (as indicated in Figure II) according to diagnosis, department, sex, and wage scale. This tabulation indicates the frequency of condition, makes possible depart-

mental comparison, and shows the relative performance between the sexes and the wage scales.

Every dispensary record previously tabulated as "Return to Work" is further tabulated on another Master Chart according to diagnosis, department, sex, wage scale, and the number of days absent. "C" indicates the number of cases, and "D" indicates the number of days absent from work (Figure III).

FIGURE II
TABULATION OF AMBULATORY CASES

February 1944 Compensation Cases	Department						Male	Salary
Diagnosis	A	B	C	D	E	F		
Contusions and Lacerations								
Burns—Thermal								
Chemical								
Eye								
F.B. in Eye + Glasses								
F.B. in Eye — Glasses								
F.B. Miscellaneous								
Fracture								
Strain and Sprain								
Back								
Knee								
Hernia								
Concussion								
Fume Exposure								
Chemical Exposure								
Dermatitis								
Miscellaneous								
Total New Compensation								
Retreatment								
Total Compensation Cases								
Welfare Cases								
Diagnosis								
Contusions and Lacerations								
Dermatitis								
Eye, Ear and Nose								
Teeth and Gums								
Throat and Tonsils								
Colds, Flu and Grippe								
Pneumonia								
Cardio-Vascular								
Genito-Urinary								
Venereal								
Gyn. and Obs.								
Gastro-Intestinal								
Hemorrhoids								
Infectious Diseases								
Strain and Sprain								
Fractures								
Neurosis								
Back Cases								
Miscellaneous								
Total New Welfare								
Retreatment								
Total Welfare Cases								

FIGURE III
ABSENTEES BY DEPARTMENTS

February, 1944	Department														Total	Females	Salary
Diagnosis	A	B	C	D	E	F	G										
	C	E	C	D	C	D	C	D	C	D	C	D	C	D	C	D	
Respiratory																	
Gastro-Intestinal																	
Arth. & Myos.																	
Operations																	
Infections																	
Genito Urinary																	
Neuroses																	
Eye, Ear & Nose																	
Dental																	
Back																	
Strains, Sprains																	
Hemorrhoids																	
Comm. Dis.																	
Fractures																	
Contusions																	
Skin																	
Feet																	
Gyn. & Obs.																	
Burns																	
Cardio-Vas.																	
Miscellaneous																	
Total Absentees																	

The tabulation in the Master Chart of Figure III permits the same study of the absentees as the previous chart did for the ambulatory cases. In addition, it includes the lost-time factor, which is a very important factor these days. It lends itself for analysis as to frequency of condition, distribution of cases, seasonal variation, sex differential, and the possible effect of certain illnesses on production as evidenced by the total sum of man days lost.

Instead of having figures which merely represent the total number of dispensary visits, we have broken down that total into numerous diagnoses and have divided the cases according to department, sex, and wage scales. The information has

thus been changed from a cumbersome, meaningless form into one that can be interpreted and studied. From this point numerous comparisons are possible; trends can be determined; and investigations can be instituted wherever a need for them is apparent. To be of value these tabulated facts must be capable of lending assistance to a better understanding of the current problems, and in some instances should be able to aid in their solution. It is in this respect that records cease being passive, merely the recording of something; they now assume an active role, since, based on their interpretation, plans for the future will be formulated.

For purposes of illustration, let us now review a specific problem, namely, absenteeism, and see how a study of the records will aid in a better understanding of the problem, and determine if that study will aid in its solution. The following charts and comments are based on some twenty thousand cases of absenteeism which have occurred during the years of 1942 and 1943.

FIGURE IV
DURATION OF ILLNESS

Per Cent of Total No.	No. of Days
35.0	1
15.0	2
9.3	3
7.0	4
5.4	5
4.0	6
3.5	7
2.5	8
2.0	9
1.6	10
1.6	11
1.2	12
1.0	13
.7	14
.7	15
.5	16
.4	17
.4	18
6.7	20+

An absentee is any employe who missed one or more days from work due to personal illness or injury.

The chart in Figure IV indicates that of the total absentees for 1942 and 1943, 50 per cent were absent

FIGURE V
COMPARISON BY PLANT DEPARTMENTS

Dept.	Per Cent of Personnel Absent			Per Cent of Personnel
	Total	Resp.	G.-I.	
A	10.2	4.1	1.8	25
B	13.0	5.8	2.6	27
C	10.5	5.0	1.5	20
D	7.7	4.0	1.6	18
E	9.2	3.8	1.6	15
F	8.2	4.0	1.4	29
G	13.0	6.1	2.4	33
H	14.1	6.2	2.6	30

Average monthly percentages based on the years 1942 and 1943.

for one or two days, and 78 per cent were absent for seven days or less.

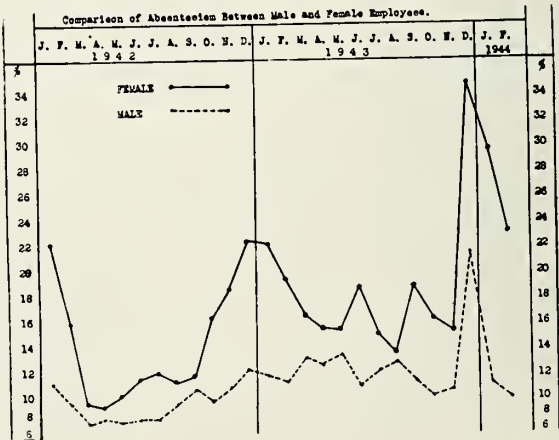
The figures in Figure V make possible a departmental comparison of absenteeism and indicate the average monthly percentage of total personnel absent for one or more days during every month for (1) all total illness, (2) upper respiratory diseases, and (3) gastro-intestinal diseases. In addition, it indicates the average monthly percentage of total personnel visiting the dispensary for ambulatory treatment for all conditions.

From these figures certain general deductions seem plausible:

- (1) Absenteeism is apparently a plant-wide problem.
- (2) The rate is equally as high among the day workers and non-operating groups as it is among the shift workers and operating groups.
- (3) Absenteeism due to upper respiratory disease is equally prevalent among those groups protected from the weather as it is among the groups exposed to the weather.
- (4) The incidence rate of gastro-intestinal disease does not seem to have any direct relationship to either the presence or absence of chemical exposure.
- (5) In comparing the various departments on the percentage of total personnel requesting ambulatory treatment for all causes, it is again indicated that the occupation per se is not a basis for predisposition to symptoms, as the day workers and groups having no chemical exposure have an equally high ratio as the operating groups.

From these figures we will conclude that the record does not indicate the presence of any definite occupational tendency toward disease. This deduction should in no way lessen the intensity of the medical surveillance of either the job or the workers, but only help to stress the urgency of its continuation.

FIGURE VI
COMPARISON OF ABSENTEEISM BETWEEN MALE AND FEMALE EMPLOYEES

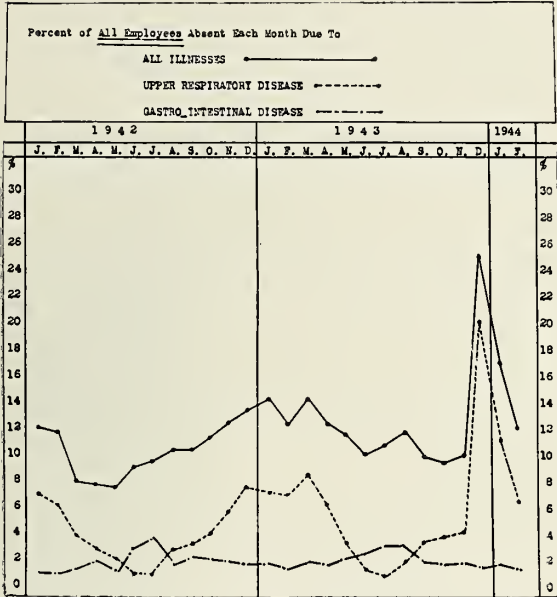


The graph in Figure VI indicates the percentage of all males and all females absent each month during the two-year period.

In comparing the absentee rate between the males and the females for the same period, the graph in Figure VI indicates a constantly higher rate for the females than for the males. There also seems to be a more pronounced seasonal variation in the case of the females. The recent "flu" epidemic had a decided effect on both sexes, but even in this specific instance the deviation from the usual seemed to be more pronounced with the females than with the males.

The graph in Figure VII indicates the percentage of all employees absent each month during the same two-year period.

FIGURE VII
PERCENTAGE OF THE TOTAL EMPLOYEES ABSENT EACH MONTH

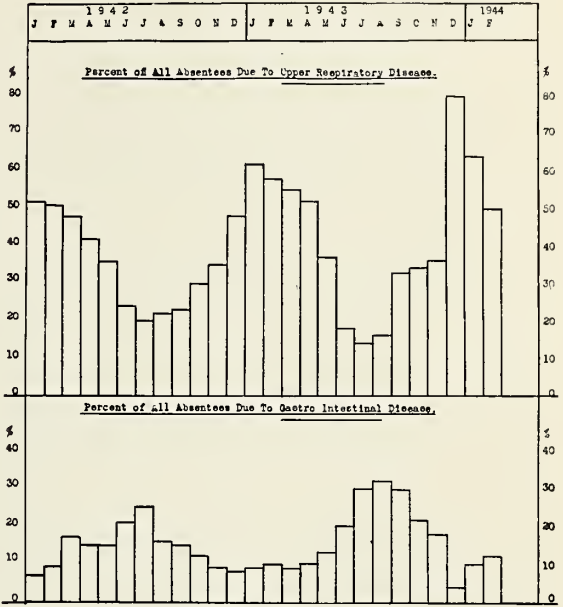


It is apparent that absenteeism due to illness in 1943 was at a higher level than the level of 1942. The graph in Figure VII also emphasizes the seasonal trends of upper respiratory diseases and gastro-intestinal diseases. The recent "flu" epidemic is very definitely reflected in this graph.

The graph in Figure VIII represents the percentage of all absentees due to upper respiratory disease and gastro-intestinal disease. It is interesting to note the marked seasonal variations between these two conditions and the almost mathematical precision with which the monthly percentages were repeated for this two-year period. The "flu" epidemic in December, 1943, was the exception, and the graph merely reflects the unusual incident.

The table in Figure IX shows a comparison of the percentage of the total number of absentees due to specific conditions. It compares the percentage of the total number of days lost due to upper-respiratory disease, gastro-intestinal disease,

FIGURE VIII
COMPARISON OF THE PERCENTAGE OF ALL ABSENTEES DUE TO UPPER-RESPIRATORY AND GASTRO-INTESTINAL DISEASE



and all other illnesses. It shows a comparison of the average number of days lost per employee during the year, and also the number of days lost per absentee during the year. It compares the per-

FIGURE IX
COMPARISON OF ABSENTEEISM IN 1942 AND 1943

Per Cent of Total 1942	Diagnosis	Per Cent of Total 1943
35.0	Upper Respiratory	45.0
15.0	Gastro-Intestinal	16.0
8.0	Arthritis and Myositis.....	5.0
7.5	Surgical Operations	3.4
6.0	Infections	4.0
3.5	Genito Urinary	2.0
3.2	Neurosis	3.5
2.5	Eye, Ear and Nose.....	2.5
2.4	Dental	3.5
2.0	Back	2.0
2.0	Strains and Sprains.....	1.0
1.5	Hemorrhoids	1.0
1.5	Communicable Diseases	1.0
1.3	Fractures .....	.5
1.3	Contusions	1.0
1.3	Skin .....	.4
1.0	Feet .....	.6
.5	Gynecology and Obstetrics.....	2.8
.3	Burns .....	.2
1.3	Cardio Vascular	1.6
2.9	Miscellaneous	3.0

1942 Per Cent	Days Lost	1943 Per Cent
22.0	Upper Respiratory	33.0
13.0	Gastro-Intestinal	13.0
65.0	All Other Illnesses.....	54.0
6	Average per Employee.....	11
5	Average per Absentee.....	7
1.9	Per Cent Total Man Days Lost.....	3.4
1.1	Ratio of Absence per Employee.....	1.6

Comparison of Absenteeism in December, 1942, and December, 1943, showing effect of "Flu"

1942 Per Cent		1943 Per Cent
12	Total Employees Absent.....	25
56	All Absentees Due to Flu.....	82
53	All Days Lost Due to Flu.....	62

centage of total man days lost during the year. It compares the ratio of absence per employe per year. Finally, it compares absenteeism of December, 1942, with 1943, to indicate the effect of the "flu" epidemic.

In reviewing the table in Figure IX there are certain figures that are outstanding: Regarding Diagnosis: increase in upper-respiratory disease in 1943; increase in gynecological and obstetrical conditions in 1943; and the constancy of gastrointestinal disease. Regarding Days Lost: definite increase is indicated in 1943. Regarding Ratio of Absence per Employee: definite increase is indicated in 1943.

The summation of all this statistical data on absenteeism, based on the number of absentees and the duration of the absence, clearly indicates a definite increase in the rate of absenteeism in 1943. There is no conjecture in arriving at this conclusion, as it is based on factual evidence obtained direct from the records. Without this factual evidence one would be compelled to substitute either personal opinion or vague generalities in an attempt to evaluate the actual status of absenteeism.

Are there any other conclusions this statistical data is qualified to substantiate regarding this problem of absenteeism? Can it offer any explanation for the increase? Can data based on incidence rates and duration explain causes? Can we assume that all other factors which exerted an influence on the plant personnel during this period remained constant, and then deduct, since absenteeism was greater in 1943, that the severity of illness was greater in 1943?

This assumption, on the surface at least, may seem logical. However, let us review the records further and determine if there were any other factors present in 1943 which in themselves could be responsible for this increase in the rate of absenteeism.

The records indicate that the average employe of 1943 was definitely below the physical standards of the employe of 1942. This was the result of the wholesale replacement of the young, healthy males by the older age groups and those having known physical handicaps and disease tendencies.

The records indicate that there was a shift of the female personnel from a 5 per cent of the total plant personnel in 1942 to a 17 per cent of the total plant personnel in 1943. This was probably responsible for not only the relative increase in gynecological and obstetrical cases but also some of the over-all increase in absenteeism, since even the records of 1942 indicated that the females had

a definitely higher ratio of absenteeism than the males.

The records indicate that a larger percentage of the plant personnel was entitled to receive welfare and insurance benefits in 1943 than 1942, based on length of company service. This change in economic status has a definite effect on sickness absenteeism, not only from the standpoint of incidence rate but also on the duration of illness as determined by the employe's ability and willingness to return to work.

There are doubtless other factors present, but these should suffice to indicate that the previous assumption was incorrect. The review of the complete records strongly suggests that the increase in absenteeism in 1943 was not due primarily to illness per se, but was the result of changes in the actual status of the plant personnel. A knowledge of these factors is essential if one is to have a clear understanding of the entire problem. This knowledge is also essential in attempting to solve the problem, as it indicates that action must be taken not only to combat illness but also along lines that will minimize the effect of these other factors.

In reviewing the records on this problem of absenteeism, we have attempted to indicate the following:

- (a) That the records can be tabulated.
- (b) That the tabulated data is capable of establishing the true status of the problem.
- (c) That caution must be exercised in the interpretation of any specific portion of the records.
- (d) That to obtain the maximum assistance from the records, it is essential to utilize all the records that have any possible bearing on the problem.

Other problems in which a study of the records proved to be beneficial would include:

1. A tabulation was made from the records of the time spent by the employe in traveling from the job to the plant hospital, as well as the purpose of the visit. Careful evaluation of this data revealed that the cost of this time lost from the job was in excess of the cost required to build and equip a more centrally-located dispensary. This was put into operation. In addition to the actual monetary saving, due to this reduction in time lost from the job, there has also been less interference with plant production.
2. Blood pressure studies on a certain group of operators was strongly suggestive of excessive chemical exposure. Investigation revealed the need for improved methods of handling the toxic chemicals. New equipment was designed and installed, and to date no recurrence of the abnormal blood pressures has been noted.
3. A preponderance of minor injuries in a certain location indicated that there was something amiss with the safety program. Investigation revealed that supervision in that location

was not insisting on employe compliance with the standard safety practices.

4. A study of absentee records indicated that these cases started rather uniformly throughout the seven days of the week, whereas 50 per cent of them terminated on Monday. A form letter was sent to every physician in the community, calling this fact to his attention and requesting his cooperation in returning the employe back to work at the earliest possible moment, whether that be on Monday, Thursday, or Saturday. The response of the physicians has been most gratifying, and a definite reduction in the number of man days lost has resulted.

More examples could be cited, but these should suffice to indicate some of the benefits that have

been derived from the tabulation and study of group records.

In conclusion, let us summarize by saying:

The complete medical records is a definite aid to the individual, the plant, and the industrial physician.

The complete medical record is a source of great satisfaction to the physician, as he sees in it a medium to perpetuate a knowledge.

Complete medical records enable the physician to keep his finger on the "pulse" of not only the individual but also the plant.

Medical records are the master key capable of unlocking many questionable situations.

Medical records are capable and essential tools—use them!

T-STACK FOR ARTERY FORCEPS

FRANKLIN E. HAGIE, M.D.

RICHMOND

In order to keep artery forceps in a more efficient and orderly arrangement on the Mayo table during operations, I have devised and am using T-stacks. By this arrangement artery forceps are more easily obtainable by the operator, and are available from the same place at all times. Forceps piled one on another, as is ordinarily done, slide apart when the top one is taken off, which always gives the table a confused and messy appearance. The table with the T-stacks in use looks the same when you have finished as it did at the beginning of the operation.

The T is made out of quarter-inch steel, an inch wide, with the horizontal bar $3\frac{1}{2}$ inches in length, and the perpendicular bar $5\frac{1}{2}$ inches in length. When aluminum is available, it will be better to

use it to make the T, rather than steel, as it will have much less weight. The pins are $2\frac{1}{2}$ inches long and are the same diameter as the holes in the T. The horizontal bar has four holes, the two nearer holes being used for the $4\frac{1}{2}$ -inch artery forceps, and the outer two holes are used when the 6- or 8-inch forceps are stacked. On the perpendicular bar there are three sets of holes, and the two to be used depends on the length of the forceps to be stacked. Four to six stacks are used during an operation, depending on the type of operation that is being done.

The T and pins are boiled with the instruments for the operation, and are apart as shown in No. 1 of cut A. The pins for all the stacks are boiled in a cup so as to have them all together. In

FIGURE I

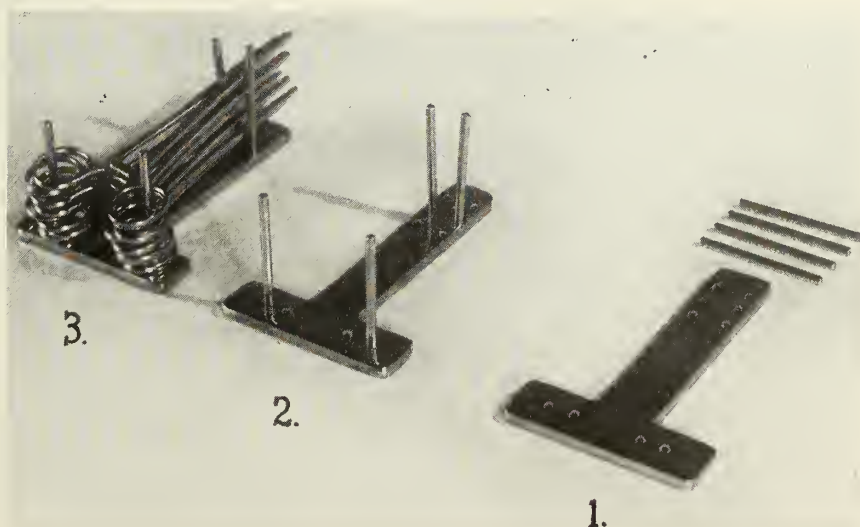
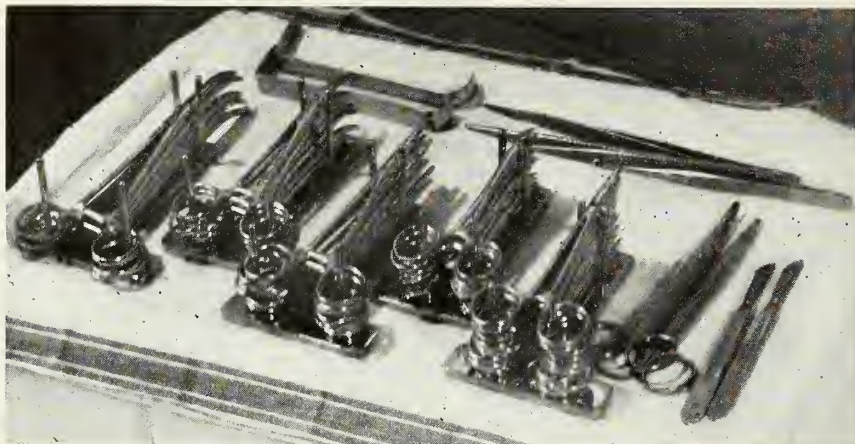


FIGURE II



setting up the table, the nurse places the pins into the T-base, as shown in No. 2 of cut A, thus completing the T-stack for use. The forceps are put in the T-stack as shown in No. 3 of cut A, and the number may vary from six to twelve. A view of the table after it has been arranged is shown in cut B. By not keeping the horizontal bars of the T-stacks in a straight line, but alternating

them back and forth as can be noticed in cut B, one can get more room on the table.

I think that the T-stack is a great convenience during an operation, and is well worth being tried by any surgeon. It should appeal especially to the Navy surgeon doing work on board ship where artery forceps would be more difficult to keep in order.

ABSTRACT

WAR HAS MORE EFFECT ON FUTURE THAN CAN BE MEASURED BY CASUALTIES

Discussing the effect of the war on civilian populations, *The Journal of the American Medical Association* for May 27 points out that in many of the occupied European countries "peace will likely find a materially smaller population than existed before the war. Thus war shakes the biologic foundations of human life and has an even more profound influence on the future than can be measured by the number of casualties."

The appalling effect of the present war on European countries is described in the same issue of *The Journal* by its regular London, England, correspondent who says:

"After the last great war it was found that "indirect war losses" greatly exceeded direct casualties. The indirect losses included the children who would have been born but for the war, the children dying in infancy as a result of wartime increased infant mortality and the civilians who died as a result of wartime epidemics and a wartime increase in the general death rate. For the present war the figures are as yet too incomplete to assess fully "the indirect war losses" in occupied Europe. But enough material continues to be collected to give some idea of their appalling extent. In France the birth rate for 1940 and 1941 was 10 per cent below the previous low birth rate. This meant in the two years 120,000 unborn children. The condition in Belgium is worse: 20 per cent below the pre-war level. The Belgian urban population subsists on about one third of the minimum diet prescribed by the League of Nations. The Netherlands, on the other hand, seems to have been spared such great losses.

"Nor have the Axis powers escaped. In Roumania the birth rate in 1941 was 15 per cent below the pre-war level. Italy in 1941 and 1942 was reduced 13 per cent in its birth rate, and Germany in the three years 1940-1942 was reduced 14 per cent. The German deficiency has now risen to 25 per cent. These are only partial

figures. The total of Europe's "unborn children" must now number several millions.

"To this loss must be added that due to increased infant mortality. In Germany this was 6 per cent higher in 1940 and 1941 than in the two preceding years. In Belgium the increase was 13 per cent. Tuberculosis takes a great toll of Belgian children. After one winter of German occupation the deaths from tuberculosis increased 57 per cent and the great majority of the new victims were children. In France the 1940-1942 infant mortality was over 20 per cent increased. In refugee camps children were reduced to 900 calories a day even in 1941. Eight million children were without shoes; 75 per cent of school children lost weight during 1941. They are over a year behind children of normal development. Eighty per cent of French babies suffer from rickets. Nearly all the skin tests performed on Paris children showed tuberculosis definitely. In Italy infant mortality in 1941 was 18 per cent higher than in 1939. In the Netherlands the increase was 20 per cent, though the Dutch are still the best off in occupied Europe. The infant mortality is the only numerical measure available for health trends. But, as the International Labor Office points out in its report, the brunt of deterioration in diet is borne by adolescent children, who are especially susceptible to tuberculosis. The average town child in occupied Europe is underfed, short of vitamins and too hungry to concentrate. The father may be dead, a prisoner of war or a deportee, and the child may spend the day in search of food, too weak for exertion, without soap to keep clean. It is on this decimated enfeebled generation that the reconstruction of Europe will depend.

"Stray scraps of news throw light on the terrible conditions. Bread is "diluted" with hydrolyzed straw or chestnut meal from which the oil has been extracted. Last year in France the average family got fish once in three months. . . . The Dutch are eating dog and cat meat. . . ."

THE JOURNAL OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

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JULY, 1944

Editorials

RELOCATION OF PHYSICIANS AND DENTISTS

The Federal Security Agency, a department of the United States Public Health Service, has sent out an announcement covering the relocation of physicians and dentists, in which all questions are clearly answered.

A community finding itself without proper medical and dental care may apply for proper assistance, using a formal application blank which is sent to the local state board of health. This application usually is made out by some official from the community.

A check in the sum of \$300 is sent with the application to cover part of the cost of transferring the professional man from his present location. It is stated that this represents about 25 per cent of such cost. However, should the cost be higher, the community is expected to share a proportionate cost of the increase.

As for the physician or dentist, there are several regulations: First, he must be duly licensed in the state to which he removes. Then he makes formal application to the United States Public Health Service, and sees to it that he is released by his State Procurement Committee. He must agree to remain in the new location at least one year.

All these forms and agreements being completed, the Public Health Service assumes all charges for moving the professional man and his family to the new location. In addition, the same agency pays the professional man \$250 per month for the first three months, this in addition to the actual cost of travel and transportation of his family and his household effects. It is planned that three-fourths of this cost be paid by the Public Health Service, and the remainder by the community affected.

It is especially emphasized that any physician or dentist who makes such a move remains as *free* as any other private practitioner. The only requirement is that he remain in the new location for at least one year.

Since the beginning of the present war there have been many inquiries regarding such removals, and the official announcement just issued covers practically all of these questions. Throughout the country there are numerous communities which would be pleased to take advantage of such an arrangement, and there probably are a number of professional men who might wish to avail themselves of this opportunity. To us this seems to be an ideal plan; the community gets a much-needed physician or dentist, while the physical transfer is made without cost to the professional man.

BRUCELLOSIS

We are a bit inclined to give THE JOURNAL a "pat on the back" in the matter of publicity concerning the more-prevalent-than-commonly-believed disease, brucellosis. Our observation has been that few state medical magazines have had as much to say on the subject, and we believe that we have spoken with authority on every occasion. Indiana is most fortunate in having had some of its younger men — men located in the smaller communities at that — interest themselves in the somewhat obscure manifestations of this disease. They wanted to know "why" and proceeded to find out, as best they could.

We do not know, of course, to what extent our presentations have stimulated investigation in other states, but the fact remains that many other state magazines are having somewhat to say on the subject. In the May issue of the *North Carolina Medical Journal*, Dr. C. Graham Reid, of Charlotte, writes of his experiences with the disease. Like most other writers, he stresses the fact that the symptomatology of this disease often is quite obscure; the patient is ill, at times very ill, yet the diagnosis is not an open one. He says, "The truth of the matter is that in those areas where the disease is looked for the incidence is high. In other areas the incidence is low because many cases go undiagnosed." He quotes another writer as saying that there is unmistakable evidence that the disease is widespread throughout the United States,

and therefore it should be classed as one of the more common diseases.

In 1927 there were but 112 cases of brucellosis reported to the United States Public Health Service, while twelve years later this figure had increased to 4,501. This, of course, did not include all such cases in the country, because of failure to report them.

There is a lot of brucellosis in Indiana, much of which remains undiagnosed and therefore untreated. There is no doubt but that hundreds of so-called "chronics" are making routine visits to the office of their physician, seeking relief from a train of symptoms that seem to vary from time to time.

The final diagnosis of brucellosis is not an insurmountable task, even in the case of the country doctor who has a modest laboratory equipment. It also would be well to check up on back numbers of THE JOURNAL for a few years, where one will find several authoritative discussions of this disease, most of them by Dr. Dan Urschel, of Merton, and Dr. Neal Davis, of Lowell.

As we have said, there are a lot of undiagnosed cases of brucellosis in Indiana, and it but remains for all of us to "wise up" on the subject and get these unfortunates under proper treatment.

OF THE MAKING OF PHYSICIANS THERE IS AN END

Thus we paraphrase an old adage to meet a present situation which is almost cataclysmic in character—that of the ruling regarding premedical students in regard to Selective Service.

The armed forces, so we are told, need 4,500 physicians, right now; this, it is stated, is imperative. Almost in the same breath comes the statement that pre-medical students no longer are exempt from military service.

The medical profession is being aroused over these pronouncements; *The Journal of the American Medical Association*, for June tenth, carries an extensive, factual editorial on this subject; our retiring A.M.A. president, James Paullin, M.D., in a nation-wide radio address as of June sixth brought to the attention of the radio public the fact that we are facing a perilous situation. Considered from any angle, the situation is indeed a vital one. There is an increasing demand for the conservation of the health of the American people; this can be brought about only in two ways: A willingness on the part of these people to cooperate, and a proper degree of medical care available to them.

Few communities in this country have an oversupply of physicians today, and many are poorly manned in this regard. With the best of conditions in the field of medical education, we still fall short of replacing physicians in the field of private practice. Some 3,500 physicians die each year in this country, and in addition to this we must face

the fact that with hundreds of medical men of retiring age continuing their practice, chiefly because of war conditions, we can reasonably expect an increase in death rate.

This annual loss must be made up in some manner, and it was hoped that by speeding up our medical schools, with continuous classes, we might be able to meet this deficit and at the same time provide the number of younger physicians needed for medical service.

There are also other factors that must be considered: it still requires a long period of study and clinical experience to become good physicians; this is one thing which cannot be shortened to a greater extent than at present — one and one-half years premedical and two and one-half years medical school training. To this must be added the intern year, which at present requires nine months. As stated above, it is our opinion that this period cannot be further abbreviated without material reduction of efficiency.

Then, too, we have the post-war period to consider. A large number of physicians now in active practice will retire; service men will be slow to return to their former locations, what with the six-months' post-war clause of their enlistment contract. Others will be retained for a considerable period in some of the foreign countries. In addition, we should bear in mind that in many of the nations now at war no medical schools have operated for some years, and medical care in those areas will become one of our problems.

It seems that we have very properly promised medical aid to some of these countries, notably China. If there is any one nation to which we owe a huge debt, it is China, and every promise made them must be fulfilled, so the problem becomes a gigantic one. It is an acute problem—we cannot take too much time in bringing forth the solution; we cannot say, "Oh, well, we will see what can be done about it later"—the time for action is here.

The suggestions of some of the "powers" certainly do not seem feasible, for instance, one in which it is recommended that premedical students be sent to college after a year of military service; and another, that enlisted men, *chosen by the Army*, be sent to premedical schools. This is wholly impractical. Just now, and probably for some time to come, the Army has a job on its hands; it cannot take time out to *properly* select a group of enlisted men to take up medical training.

Our medical schools have mulled over the problem of how best to select medical students for many years, finally arriving at what we believe to be *the* solution. We are inordinately proud of the committee from the Indiana University School of Medicine which handles this matter. They are doing a good job, and no organization should undertake to supplant this system.

This, as we have said, is a most acute problem. It will have to be solved right now! It has been

suggested by *The Journal of the American Medical Association* that if everything else fails the matter should be laid before the President and before Congress. There is too much at stake — the future health of the American people — for any haphazard method to be adopted. (We have not even mentioned the medical problems to come — the post-war care of the casualties that will be returned to this country.)

It behooves every medical man in the country to exercise his best efforts in a proper adjustment of this dangerous situation.

SOLICITATION RACKETS

"War Rackets," and the term is most aptly used, are becoming more and more common these days. In one issue of the Indianapolis *Better Business Bureau Bulletin* no less than seven of these fakes are exposed. It seems that several folk have a yen for publishing "War Hero" books, a few of the proposed titles being listed as "American Heroes of the War in the Air;" "Heroes of World War II;" and the "Honor Rolls."

The latter sell at the modest price of one dollar, while the books sell for ten dollars. The "Honor Roll" gag consists of pasting a newspaper report of a war casualty on cardboard, the borders being embellished with an artistic drawing.

Then there is the State Organization of the Purple Heart, which campaigned to sell medallion pictures of men in service, at five dollars each, to industrial plants, the medallions to be given the families of the servicemen, the proceeds to be used in rehabilitation work, it was announced. The *Bulletin* says that an investigation showed that *eighty cents* of each five dollar sale would be given over to rehabilitation.

"Dogs for Blinded Veterans" is another scheme for raising money. Somehow the story has gotten around that thousands of our servicemen have been blinded via war casualties, and that a lot of trained dogs will be needed as guides for these victims. The War Department recently issued an official statement to the effect that seventy-nine servicemen had lost their vision thus far.

"Overseas Cigarette Service" is the title given another racket, the operator of which was recently arrested in New York City. The District Attorney stated that this chap had profited to the extent of \$11,000 thus far. His plan was to interest business and professional men in donating \$75, to be used in sending 1,000 packs of cigarettes to servicemen overseas. It was learned that the cigarette manufacturers stand ready to furnish this package service for the sum of \$50. Neat little profit for the chap who ran the game!

"Walk-a-Chair" solicitations were sent out by the Army and Navy Union, U. S. A., this outfit having its headquarters in Akron, Ohio. They mailed out stamps, asking the recipient to remit two dollars. The *Bulletin* says, "Our information

is that the United States Government is prepared to assume full responsibility for the physical and vocational rehabilitation of our crippled veterans."

While this may appear to be a formidable list, we may expect a marked increase in war rackets from now on and during the immediate post-war period. In most cities we have organizations which check up on these various forms of solicitation; hence, it would be well to ask their opinion each time we are asked to make a donation or buy this or that gadget.

It is, of course, commendable to contribute to worthy causes, but if you find yourself possessed of surplus cash we would suggest that you trek right down to your bank and buy War Bonds. You are thus assisting the war effort, and at the same time building up your cash reserve.

Look with suspicion upon every solicitation coming from strangers, either by mail or in person; there still are too many folk making a living by their "wits."

THE BARUCH GRANT

A brief comment was made in the June issue of THE JOURNAL concerning the gift of Bernard M. Baruch, in the sum of \$1,100,000, for the purpose of establishing scientific research in physical medicine. The committee in charge, headed by Dr. Ray Lyman Wilbur, chancellor of Stanford University, has issued a statement covering the present plans of the committee. It seems that Mr. Baruch, in addition to his most generous gift, has financed the preliminary work of the committee, which has set up headquarters in New York City.

The committee has named several institutions which will participate in this work and has awarded grants to carry out the program. The institutions already named, together with their allotments, are:

1. Columbia University, \$400,000. This will be the key center of research and teaching of physical medicine. The sum allotted is to be used over a period of ten years.

2. New York University College of Medicine, \$250,000. This is also to be expended over a ten-year period, and the university will also be a teaching center.

3. The Medical College of Virginia, \$250,000, to be used in special teaching. This school was the alma mater of Dr. Simon Baruch, the present donor's father.

4. To selected medical schools, not yet named, \$100,000 has been allotted for the development of an immediate program for the rehabilitation of war casualties, as well as those injured in industry.

5. One hundred thousand dollars was given for the establishment of fellowships and residencies, this for the benefit of qualified physicians and scientists who are to be selected for this special training.

Thus, it will be seen that this is no hit or miss

program, neither has it been planned in one grand rush. It is evident that much time and thought have been given to the many details, to the end that when the "go" sign is given the whole program will click.

It is stated that the gift of Mr. Baruch was animated because of his belief that physical medicine has long been a sort of stepchild of medicine proper. He felt, as many of us have felt for a long time, that an investigation should be made of the various forms of physical therapy, and this is just what will be done.

The various claims of the cultists not only will be analyzed and carefully studied, but will be tried out, and this "trying out" process will be directed by scientists of unquestionable standing. A case in point might be cited, that of the much-advertised "Radioclast." This gadget, selling to gullible cultist practitioners, might well have been named "the miracle machine"; there seemed no end to what it could do in the way of diagnosis. It even rivaled the magic of "the little black box" contrived by an Indianapolis cultist and used by him for a long time in extracting fees from the public.

The "Radioclast" has been dissected, has been studied by some of our foremost scientists, and has been declared a "fake" of greatest proportion.

Mr. Baruch thus has made possible a thing that many medical men over the country have been asking that our medical leadership carry out for, lo, these many years. We even have demanded that a special study be made of these various devices so strongly alleged to be the *sine qua non*. Now it can be done; it will be done—and done through a committee in whom we have the utmost confidence.

The published findings of this committee will be broadcast to the medical world, not overlooking the important lay factor. THE JOURNAL will keep in close contact with this program and will from time to time print such reports as are available.

Editorial Notes

The October convention, in Indianapolis, will be "slanted" toward the Air Corps. We have had an Army meeting and a Navy meeting; now it becomes the turn of the Air Corps to be thus honored. We have been advised of the activity of a high official in the Air Corps, who has charge of such matters, and who has sent a tentative list of contributions for our convention issue. The Air Corps will be represented on the program, and in addition we will have the usual list of local participants—all tending to make this meeting an outstanding success. And, just one more reminder: Have you made your hotel reservation? That is a mighty important matter these days.

An article in a recent number of *The Journal of the American Medical Association* points out the value of sea bathing for convalescents; however, we are not advised just how to get to the said sea coast with the limited travel accommodations offered these days.

In 1939, when Hitler moved into Poland, the maximum production of steel in this country amounted to 82,000,000 tons annually; less than four years later this had been stepped up to something like 90,000,000 tons, and this capacity is being increased from time to time. The steel industry has played, and is playing, a major role in the present global war.

Along with the many other problems confronting the hospitals of today comes the matter of help. This is a very acute problem in many areas, as is evidenced by the decision of the Indianapolis Methodist Hospital to close one of its floors with a bed capacity of 33. Dr. John G. Benson has announced that this move had become necessary because of inability to get sufficient help, either trained or volunteer, to operate this department. Although the White Cross Guild of the Methodist Hospital provided more than 78,000 hours of assistance last year, the manpower situation has become so acute as to bring about the closing of this section of the hospital. It *does* seem that some provision should have been made for hospital help; first they took large numbers of our nurses, then our interns and residents. Even some of the orderlies were taken from our hospitals—all of which left matters in a chaotic state.

We still recommend a vacation for every physician, but warn that getting equipment together is a problem these days, particularly for those in quest of the finny tribe. New rods and reels, as well as many other items, are hard to find—some not available at all. We suggest getting out the tackle box, looking up the rods and reels and seeing what can be done about them. Our personal experience was very pleasing when we learned that two rods that long since had been laid aside could be made as good as new, what with an agate guide or two and a re-winding. So it was with several other items; reels that had not functioned properly were repaired, artificial baits gone over, hooks sharpened, leaders checked, et cetera, and now our tackle box looks as it did in old times. The only problem is "transportation;" the car is definitely out, and train service, even the "fisherman specials," are sold out weeks in advance. However, these inconveniences but add to the enjoyment of fishing in Canadian waters, once we get there.

Various medical writers continue to emphasize the menace of tropical diseases, once the war is ended and the millions of our young men return home. To our mind, the menace of malaria is one of the outstanding things to be guarded against. Most every section of the country has mosquitoes, many varieties of which are known carriers. Mosquito control, we believe, is one of the most urgent "musts."

Dean Jenkins, of the Purdue School of Pharmacy, in a recent address remarked that until the turn of the present century about two-thirds of the drugs used in the treatment of diseases were of natural origin, but that in the last ten years this order has been exactly reversed. The Dean waxed rather enthusiastically about the advances in medicine and pharmacology, it is reported, even going so far as to envision a Disease-Free Age.

We are very much in accord with the suggestion of Dr. Harold M. Camp, secretary of the Illinois State Medical Society, to the effect that there should be a nation-wide committee of physicians that could offer its advice and cooperation to any bureau entrusted with the administration of a medical program.

Some of the "high jinks" proposed and even carried out by the Children's Bureau prove that sane, sensible, informative advice would be in order.

Three Army hospitals; Deshon General, located at Butler, Pennsylvania; Borden General, at Chickasha, Oklahoma; and Hoff General, at Santa Barbara, California, have been equipped for a special study of the use of hearing devices for men suffering from loss of hearing as a result of current war injuries. The examination includes a complete physical check of the patient, together with a careful analysis of his hearing and a determination as to whether the more modern hearing aids will be of benefit to the patient.

It gave us much personal pleasure to read of the honor recently conferred on two of our good friends up Minnesota-way, Drs. W. L. Burnap and W. F. Braasch. At the recent Rochester session of the Minnesota State Medical Association these men were honored with the "Distinguished Service Award." In each instance the honor is highly merited, for we know of but few men over the country who have done so much for organized medicine, not only within their own state but in the affairs of the American Medical Association. They had much to do with creating sentiment that resulted in the formation of the Council on Medical Service and Public Relations, as well as the setting up of an official headquarters in Washington.

Rheumatic fever in children is a subject that just now is receiving much attention in medical circles, and Dr. Morris Fishbein recently has pointed out that many of these children need special hospital care—care of the sort that usually is not obtainable in most general hospitals. We would like to have some articles from our own members on the subject of rheumatic fever, relating how *you* manage these cases.

It has been said that THE JOURNAL keeps well away from discussions of matters of a political nature. It is the policy of the present editorial staff to refrain from such discussions. However, the editor of a southern medical journal recently published ideas with which we agree concerning an event that recently occupied the attention of the entire nation and brought forth a general criticism. We repeat the observations of this very warm friend:

"The seizure of Montgomery Ward by the President calls for clear and earnest thinking on the part of Americans. There is every need that the extent of the powers a president holds in wartime should be fully explored by Congress and that the full story should be given to the public."

It is difficult to rationalize this action with our vaunted American system. Medicine needs the power that the government may have over it at a time like this. If out of a controversy as this one there should come a more widespread acceptance of the "Four Freedoms" here at home, the gain would be well worth the disturbance.

The *New Orleans Medical and Surgical Journal* has reached the ripe old age of one hundred years, as of May, 1944. Several pages of this number are given over to an article by Rudolph Matas, of New Orleans, who graduated in medicine in 1880 and a short time later became editor of that publication. Doctor Matas finds great satisfaction in having had a part in the celebration of the fiftieth and seventieth anniversaries, as well as the present one. He details the trials that beset medical publishers of long ago, as well as some in later years. He lists the various editors, as they came and went, as well as the ownership of the publication. The state medical society took over in 1922. Dr. John H. Musser took over the editorship in 1927, and during the intervening years has done a good job in maintaining the traditions of this venerable magazine. Several pages are devoted to pictures of the various editors during the century. It is noted that the great majority of the early editors wore beards, many of them of the bushy variety. Along about 1890, it is noted, whiskers seemed to go out of style for editors. Some articles pertain to the medical history of the state in the past one hundred years, making this issue a most creditable number.

President's Page

Fifty per cent of the young doctors now coming out of medical schools are going into some special branch of medicine. It is not yet apparent that any of the specialties are overcrowded, but there is a woeful lack of general practitioners.

The young man entering medicine cannot be blamed for wishing to limit his work to some special field. The fees are much better, the hours are more desirable, and there is not so much labor and self-sacrifice involved.

In the present crisis the average citizen has experienced no difficulty in obtaining special medical services, but he has voiced his irritation when, in a city full of specialists, he has been unable to find a doctor who would make house calls. Most people become ill while at home and their first need is to have a physician visit them; they need a general practitioner.

The general practitioners are the infantry in the army of medicine. It is theirs to slog through the mud and tramp through the dust, and to stand long hours watching and waiting. They cannot call any hour of the day or night their own; social pleasures and hours of recreation are not for them. There is no glamour in their accomplishments, no public applause, and a small financial return.

It is necessary for the successful general practitioner to know enough about surgery to diagnose correctly and quickly all of the acute surgical conditions that arise or he will be too late in referring his patient to the surgeon. He must know enough about the diseases of the eye to detect conditions requiring the services of a trained ophthalmologist. He must know pediatrics, skin diseases, orthopedics, obstetrics, and gynecology. He must also know the limitations of the various specialists in his community so that he may intelligently direct his patients.

Standards have been set up for specialists, so that they may be trained in their particular specialty. Post-graduate courses and hospital residencies are offered to complete their preparation; then they may be certified as diplomates and qualified as worthy of public confidence. The general practitioner is offered no such opportunity. He may obtain a one-year rotating internship, but nowhere is any provision made for his training beyond that point. He will be given no certificate or diploma testifying as to his ability. No medical school offers any special training, and no hospital has a residence that will especially fit him for general practice. In the eyes of our medical schools and the public, one general practitioner is regarded as being just as well qualified as another. However, there are some compensations for the family doctor; compensations of the intangible sort. He is closer to the hearts of the people he serves than any other man on earth. He has a place in every family circle. If there were enough of him to supply all of the families in America, there would be no Wagner-Murray-Dingell bills.

In every undertaking there must be those who will "hew the wood and fetch the water." This has been the task of the general practitioner. It is an humble task, laborious and ill paid, but throughout the centuries there has been a succession of noble men to perform it. There has been a real contribution to the comfort and well being of the human race. Without them there can be no adequate medical care as we have known it in the past. As the ranks of the general practitioners gradually thin out, the cry for socialized medicine grows stronger and stronger.

It is, perhaps, wishful thinking to believe that the general practice of medicine will long survive. The drudgery, the self-sacrifice, and the lack of emolument have cast a shadow over this branch of medicine. It no longer attracts bright young men who are mindful of their future. If the profession itself abandons this field where it has so long served mankind, the people must of necessity find some other means of obtaining medical care.

Josephant

1944 SESSION OF THE AMERICAN MEDICAL ASSOCIATION

F. S. CROCKETT, M.D.

LAFAYETTE

The annual session of the American Medical Association was held in Chicago, June 12-16, and included a full scientific program this year, due largely to improvement in transportation and a realization that we all needed stimulation and inspiration from a professional standpoint. The medical services of the armed forces contributed liberally concerning the results of their experiences with the recent advances in therapy and surgery.

The Scientific Exhibit at the Palmer House, while operated without the benefit of air-conditioning, was jammed with a sweating and milling multitude whose enthusiasm could not be dampened by the excessive perspiration.

The House of Delegates met under much better thermal circumstances. Evidently having in memory the excessive heat generated at recent meetings, care was taken to have the Red Lacquer Room kept at a temperature inducing the delegates to keep their coats as well as their shirts on. The highlights of the session were three in number: The threat to medical education in the recent order of the Manpower Commission, announcing "No deferments to premedical students after July 1," seemed very real and action was taken asking that deferments be restored.

The Council on Medical Service and Public Relations asked and received a clearer definition of its authority. There seemed to be some question whether the umbilical connection joined the Council with the Trustees or the House of Delegates. Solution was found in a bit of surgery. The cord was tied and cut, and the Council began to live its own individual life. Vigorous and farsighted leadership should now dominate its thinking and action.

The AMA was organized along democratic lines. Authority starts at the county-society level, shaping up into the component state society where autonomy and state rights are assured and often jealously guarded. This has been experienced in the past, when the national association has undertaken to be helpful without first being invited. President Paullin pointed out in his address that this is not always helpful, as instanced by some state societies taking action not in harmony with action or principle made previously by the AMA House of Delegates. Since all action of the AMA Delegates is in theory also the action of the delegates from each state, the question of how binding the action of delegates is on their component state society should be settled for the sake of harmony. Yet harmony is not always desirable, should it lead to a stifling of original thinking. There is less progress in agreement unless diversity of thinking precedes it, which means that any rule on the national level

that regulated action on the state or county levels would give only a semblance of unity and would be extremely dangerous. Throughout the profession there is much criticism of those charged with the executive administration at headquarters in Chicago, complaint often centering on absence of leadership. To expect such leadership is evidence of lack of understanding our national association. Leadership can not be expected from the executive secretary or the board of trustees, since they have authority only to carry out the mandates of the House of Delegates. This throws all leadership onto the delegates, but the delegates, while very competent and wise men, have only a state or, at most, a sectional experience. Meeting only once a year, with no provision made for pooling their ideas except through the formal presentation of resolutions and the action of reference committees made up of men with limited or state experience, it is remarkable that we do as good a job as we do.

Corporations of national scope have prepared tentative plans to guide them, often covering ten to twenty years ahead. Constant revision is made as new facts are found. American Medicine could well profit by similar planning. The Council on Medical Service and Public Relations could supply, as one of its activities, the desired leadership.

The action of the California Society, aimed at a change in the headquarters' personnel, received little support from the House of Delegates. This vote, however, did not accurately reflect the thinking of many who felt the resolution too drastic. Advancing years take their toll, and knowledge of this should require adequate development of undersecretaries and assistants in all departments able to carry on in any emergency. Too often we allow loyalty to valued friends take precedence over the greater loyalty we owe the profession as a whole.

One resolution presented by Major George Dillinger received favorable action. It called for creation of personnel in the states, thoroughly acquainted with the professional, scientific, economic and political problems that beset us—such speakers to be on call for all occasions where factual presentations are required. Also was included personnel for liaison with state societies at their annual meetings and throughout the year.

Dr. Roger Lee, of Boston, Massachusetts, retiring chairman of the Board of Trustees, was named President-elect. He has been invited to be the principal speaker at our next October fourth meeting.

Everything considered, the meeting this year was very satisfactory. We all came home inspired and with renewed enthusiasm.

A.M.A. CONVENTION NOTES

Some two hundred eighty-five Indiana physicians, the majority of them away from their busy practice on the home front or from duty with the armed forces for the first time in more than a year, attended the ninety-fourth annual session of the American Medical Association in Chicago during the week of June twelfth. This war meeting, coming the week following the invasion, was, on the whole, a most serious conference, filled with the discussion and consideration of complex and difficult problems, by the seven thousand busy physicians who had gathered there from over the country. Not only were the most recent developments in medicine, drugs, and surgical procedures covered—highlighted by actual combat reports direct from the battle areas—but subjects economic, political and social in nature, such as hospital and health insurance, were explored.

The Indiana physicians, led by their president, Dr. J. T. Oliphant, of Farmersburg, took an active part in these procedures. Questions of economic nature were considered by the House of Delegates, the legislative body of the American Medical Association. Indiana's delegates were: Dr. Homer E. Hamer, of Indianapolis; Dr. Don F. Cameron, of Ft. Wayne; Dr. F. S. Crockett, of Lafayette, and Major George Dillinger, of French Lick. Dr. Cameron served as chairman of the important Reference Committee on Hygiene and Public Health, and Dr. Hamer served as a member of the Committee on Legislation and Public Policy. Dr. Roscoe L. Sensenich, of South Bend, served as vice-chairman of the Board of Trustees.

Alternate delegates from Indiana were: Dr. J. E. Ferrell, of Fortville; Dr. A. S. Giordano, of South Bend; Dr. A. M. Mitchell, of Terre Haute, and Dr. Norman A. Beatty, of Indianapolis, who is also co-chairman with Dr. J. William Wright, of the Legislative Committee of the Indiana State Medical Association.

Other officers of the Indiana State Medical Association attending the meeting were: Dr. N. K.

Forster, of Hammond, president-elect; Dr. A. F. Weyerbacher, of Indianapolis, treasurer; Dr. Cleon A. Nafe, of Indianapolis, and Dr. Carl McCaskey, of Indianapolis, members of the Executive Committee; Dr. John Ray Newcomb, of Indianapolis, vice-director of the Procurement and Assignment Service of Indiana; Dr. E. M. Shanklin, of Hammond, editor of *THE JOURNAL*, and Dr. Floyd T. Romberger, of Lafayette, chairman of the Council.

Dr. Robert J. Masters, of Indianapolis, was secretary of the Section on Ophthalmology of the American Medical Association, and Dr. Raymond C. Beeler, of Indianapolis, was a member of the Executive Committee of the Section on Radiology.

Among the Indiana physicians who took part in the scientific program were: Major Walter J. Aagesen, of the Medical Corps, who discussed "Penicillin"; Dr. McCaskey, who spoke on "The Importance of Pathology of the Nasopharynx"; Dr. Arthur P. Echternacht and Dr. John A. Campbell, both of Indianapolis, who discussed "The Value of Films of the Abdomen"; Dr. Romberger, who spoke on "Continuous Spinal Anesthesia"; and Captain Ralph S. Sappenfield, of the Army Medical Corps, who addressed the group on "The Effect of Moisture on the Absorption Efficiency of Soda Lime." Dr. Gordon W. Batman, of Indianapolis, was a member of the corps of demonstrators in the "Fracture Exhibit."

Indiana physicians manned two of the Scientific Exhibits. Dr. William Hugh Headlee and Dr. C. G. Culbertson had an exhibit sponsored by the Indiana University School of Medicine, on "Parasite Infections in Indiana." This exhibit showed the variety of parasitic infections now found in Indiana, such as malaria, amebic dysentery, Rocky Mountain spotted fever, trichinelliasis, hookworm disease, and pinworm infection.

Dr. Paul N. Harris and Dr. K. K. Chen, of the Lilly Research Laboratories, had an exhibit on "Experimental Liver Injury," which received a Certificate of Merit award.

PROVISION OF MEDICAL CARE

"The medical profession has never desired to remain static in any of its efforts of accomplishments; particularly is this true at a time such as this, when the entire world is in a turmoil and chaotic conditions prevail among all other nations as well as our own. Problems of medical care are fundamental to the reconstruction and rehabilitation of our nation. Necessary changes must occur in the distribution of medical care to make it more generally and easily available and at a lower cost without the slightest diminution in quality. The medical profession must take the lead in constructively planning these evolutionary changes. The question of sickness insurance, on a compulsory or on a voluntary basis, is one of the great problems which must be considered as a means of reaching this end. Conceivably, the federal government might wish to encourage compulsory sickness insurance by offering subsidies to states in which such programs are developed, and it is also conceivable that federal aid might become available for the encouragement and expansion of voluntary insurance plans. The rapid increase in the number of those who are insured against hospital costs, medical costs, accidental injury and sickness is evidence that the American people still desire to express their own independence and provide care for themselves. Industry has developed its own type of pre-payment insurance against the cost of medical care by furnishing hospitalization and medical service supplied by physicians on a full-time basis. With these methods and other proposals which undoubtedly will develop there is brought up for consideration many questions of policy which can be met only by adequate consideration by the governing body of this Association."

(Excerpt from address of Dr. James E. Paullin, President of the American Medical Association, to the House of Delegates at the A.M.A. meeting held in Chicago, June 12-16, 1944.)

INDIANA PHYSICIANS WHO REGISTERED AT A.M.A. MEETING IN CHICAGO JUNE 12-16, 1944

- Amick, Charles L., Wakarusa
 Berghoff, Raymond J., Ft. Wayne
 Bethea, Dennis A., Hammond
 Boys, F. F., East Chicago
 Biekel, David A., South Bend
 Burk, James M., Decatur
 Carlo, Ernest R., Ft. Wayne
 Carter, F. R. N., South Bend
 Christophel, Verna, Mishawaka
 Cole, Ira, Lafayette
 Cooper, Harry L., South Bend
 Cooper, Leo K., Gary
 Covalt, Nila K., Muncie
 Craft, Kenneth L., Indianapolis
 Dalton, John Erie, Indianapolis
 Danicleski, L. J., Gary
 Darling, Dorothy Ruth, South Bend
 Davis, Alice H., Hammond
 Davis, Carl M., Valparaiso
 Davis, Lloyd N., Mentone
 Dittmer, S. E., Kouts
 Doneghy, Charles J., East Chicago
 Doty, J. Robert, Gary
 Fargher, R. A., LaPorte
 Ferrell, Jesse E., Fortville
 Fish, C. M., South Bend
 Fleming, Claude F., Elkhart
 Foreman, Harry L., Indianapolis
 Frith, L. G., South Bend
 Glock, H. E., Ft. Wayne
 Hardy, John J., North Liberty
 Herschleder, M., Gary
 Herzer, C. C., Evansville
 Holdman, Lillian S., South Bend
 Holmes, Col. C. D., Frankfort
 Jackson, James William, Indianapolis
 Kleindorfer, R. L., Evansville
 Komoroske, J. E., East Chicago
 Kramer, Albert A., South Bend
 Kuhn, Hedwig, Hammond
 Kunkler, Joseph, Terre Haute
 LaBier, C. R., Terre Haute
 Larson, G. O., LaPorte
 Lieberman, Arnold, Gary
 Lindenmuth, E. O., Indianapolis
 Lyons, Robert E., Jr., Bloomington
 McCarthy, J. A., Whiting
 McFarland, C. B., South Bend
 Mehl, Rudolph A., Evansville
 Mervis, Frank H., East Chicago
 Montgomery, Lall G., Muncie
 Moser, Rollin H., Indianapolis
 Mothersill, Mark H., Indianapolis
 Parker, Carl B., Wingate
 Rawles, Lyman T., Ft. Wayne
 Rhamy, B. W., Ft. Wayne
 Ricketts, J. W., Indianapolis
 Riggs, Floyd, Terre Haute
 Romberger, Floyd T., Lafayette
 Rosenheimer, Geo. M., South Bend
 Ross, Milton S., Columbus
 Sennett, C. M., South Bend
 Smith, James S., Muncie
 Southard, C. B., Noblesville
 Stauffer, Walter A., Elkhart
 Streib, Frederick, Redkey
 Tinney, W. E., Indianapolis
 Van Reed, Earl, Lafayette
 Viney, Chas. L., Logansport
 Austin, M. A., Anderson
 Ballard, Robert Jackson, Lebanon
 Beatty, Norman M., Indianapolis
 Becker, Philip H., Crown Point
 Beeler, Raymond C., Indianapolis
 Black, Claude S., Warren
 Bond, George T., Indianapolis
 Blum, Leon L., Terre Haute
 Booher, Olga Bonke, Indianapolis
 Bowers, Jesse W., Ft. Wayne
 Bradfield, John, Logansport
 Cole, R. E., Muncie
 Combs, Charles N., Terre Haute
 Combs, Pearl B., Evansville
 Cring, George V., Portland
 Crockett, Franklin S., Lafayette
 Culbertson, C. G., Indianapolis
 Dillinger, George R., French Lick
 Dollens, Claude, Oolitic
 Ebert, J. Wayne, Indianapolis
 Egan, B. W., Logansport
 Eviston, J. B., Huntington
 Faltin, Ladislavs, South Bend
 Forry, Frank, Indianapolis
 Frankowski, Clementine, Whiting
 Galbreth, J. P., Burnettsville
 Giordano, Alfred S., South Bend
 Grayston, Wallace S., Huntington
 Haller, Thomas C., Williamsport
 Hamer, Homer G., Indianapolis
 Hamilton, E. E., Dayton
 Hardesty, Kile C., Capt. M.C.,
 Ft. Wayne
 Harmon, V.E., South Bend
 Harris, Robert F., Noblesville
 Hartley, Sr., C. A., Evansville
 Hauss, Augustus P., New Albany
 Hedrick, Robert Milton, Gary
 Harris, Paul N., Indianapolis
 Herring, G. N., Piercetown
 Hines, Don Carlos, Indianapolis
 Ingwell, Gny B., Knox
 Jennings, Loren Earl, Garrett
 Johnson, Gardner C., Evansville
 Kahan, Harry Leo, Maj. M.C.,
 Indianapolis
 Kraft, Haldon C., Noblesville
 Lapenta, Vincent A., Indianapolis
 Larkin, B. T., Indianapolis
 Lord, Glen C., Indianapolis
 Marks, O. L., East Chicago
 Masters, Robert L., Indianapolis
 McCaskey, C. H., Indianapolis
 Mitchell, A. M., Terre Haute
 Mitchell, Raymond E., Indianapolis
 Morrison, J. T., Greensburg
 Mowrer, Giles E., Jeffersonville
 Murdock, Harvey L., Ft. Wayne
 Nafe, Cleon A., Indianapolis
 Naugle, Raymond A., Wabash
 Nay, Ernest O., Terre Haute
 Nie, G. M., Huntington
 Norris, Mary Alice, Indianapolis
 Oliphant, J. T., Farmersburg
 Owens, T. R., Muncie
 Pearson, Lyman R., Indianapolis
 Peek, Franklin B., Indianapolis
 Petitjean, Harold G., Haubstadt
 Petranoff, T. V., Indianapolis
 Rafacz, Michael E., Whiting
 Ratcliffe, A. W., Evansville
 Reisler, Simon, Indianapolis
 Rice, Raymond M., Indianapolis
 Royster, Hollace R., Frankfort
 Rutherford, C. W., Indianapolis
 Sanderson, Robert B., South Bend
 Scott, V. Brown, Shelbyville
 Sensenich, R. L., South Bend
 Shanklin, E. M., Hammond
 Shoup, H. B., Greentown
 Spangler, Jesse Samuel, Bunker Hill
 Stewart, Fletcher C., Evansville
 Teixler, Victor A., Indianapolis
 Thompson, John V., Indianapolis
 Thornton, H. C., Indianapolis
 Van Buskirk, E. M., Ft. Wayne
 Vore, Hugh A., East Chicago
 Wall, Joseph A., Wabash
 Wheeler, H. H., Indianapolis
 Wiedemann, Frank E., Terre Haute
 Derian, M. H., Gary
 Detrick, H. W., Hammond
 Eby, Ida L., Goshen
 Echternacht, Arthur P., Indianapolis
 Eriksen, Lester G., South Bend
 Evans, Robert M., Russiaville
 Ferry, Paul W., Kokomo
 Frank, John R., Valparaiso
 Frash, D. W., South Bend
 Gable, Homer B., Monticello
 Glaser, Robert Edward, Brookville
 Gorman, H. C., Hammond
 Gutierrez, Frank A., Gary
 Hansen, Arthur H., Hammond
 Hostetler, Carl Milton, Goshen
 Hull, Arthur W., Elkhart
 Hurley, Anson G., Muncie
 Hyde, Carroll C., South Bend
 Klepinger, Harry E., Lafayette
 Lingeman, Byron N., Crawfordsville
 Logan, Francis W., Mishawaka
 Lynch, Harold D., Evansville
 Malmstone, F. A., Griffith
 McClain, M. L., Scottsburg
 McMuntry, L. K., Evansville
 Miller, S. T., Elkhart
 Mitchell, Harry F., South Bend
 Moats, Carl F., Ft. Wayne
 Page, Irvin H., Indianapolis
 Pollock, Ellis L., Vincennes
 Rasmussen, Ruth F., South Bend
 Rice, Thurman B., Indianapolis
 Rokey, Noah A., Ft. Wayne
 Row, Perrie Quentin, Hammond
 Rudesill, C. L., Indianapolis
 Savery, Charles E., South Bend
 Scott, Irvin H., Sullivan
 Short, John T., Ft. Wayne
 Steffen, Arthur J., Wabash
 Stimson, H. R., Gary
 Streck, Francis A., Lawrenceburg
 Tindal, Edward F., Muncie
 Wilson, Ralph, Evansville
 Wurster, Herbert Chas., Mishawaka
 Wygant, M. D., Mishawaka
 Wyland, Byron J., Mishawaka
 Baitinger, H. M., Gary
 Balla, Morris, South Bend
 Bishop, Charles Allan, South Bend
 Braginton, Fred, Hammond
 Brauer, Abraham A., East Chicago
 Bruckner, Doste F., Ft. Wayne
 Cassidy, J. Vernal, South Bend
 Douglas, G. R., Valparaiso
 Ferrara, Donald W., Peru
 Foster, N. K., Hammond
 Freeman, Floyd, Goshen
 Gastineau, Frank M., Indianapolis
 Hill, Howard E., Muncie
 Howard, William H., Hammond
 Huffman, Park, South Whitley
 Jaeger, Alfred S., Indianapolis
 Jones, E. S., Hammond
 McGaughey, Walter M., Greencastle
 Martin, Will, Kokomo
 Mercer, S. Robertson, Ft. Wayne
 Metcalfe, Grant E., South Bend
 O'Connor, James J., East Chicago
 Roach, Carroll E., Indianapolis
 Sandoz, Louis A., South Bend
 Schlesinger, Jacob, Hammond
 Schmiedicke, P. H., West Lafayette
 Spenner, R. W., South Bend
 Steffen, J. T., Wabash
 Armstrong, Thomas D., Michigan City
 Batman, Gordon W., Indianapolis
 Baylor, John E., Lt., Bacr Field
 Beggs, Lowell F., Columbus
 Brooks, Herry Lewis, Michigan City
 Bolin, Robert S., Camp Atterbury
 Bowman, George W., Indianapolis
 Boyd, David A., Jr., Indianapolis
 Brandman, Harry, Whiting
 Custer, E. W., South Bend
 Davis, Neal, Lowell
 DeWitt, C. H., Valparaiso
 Duemling, Werner W., Ft. Wayne
 Eggers, Henry W., Hammond
 Elledge, Ray, Hammond
 English, J. Paul, South Bend
 Fipp, A. L., Rome City
 Frash, Mahlon G., Lafayette
 Gardner, M. D., Michigan City
 Hinkson, George Duncan, Gary
 Kenney, W. U., Newcastle
 Klingler, M. O., Plymouth
 Krieger, Geo. M., Michigan City
 Kruse, Edward H., Ft. Wayne
 Kuhn, Hugh A., Hammond
 Lutz, Georgianna, Gary
 McGuire, Desmond F., East Chicago
 May, R. Milton, Gary
 Miller, Milo, South Bend
 Morris, William F., Ft. Branch
 Mozingo, Arvine E., Indianapolis
 Murphy, Josephine F., South Bend
 Ruddell, Keith R., Indianapolis
 Scott, Frank M., South Bend
 Shandling, Philip D., Hammond
 Simon, A. R., LaPorte
 Thrasher, John R., Indianapolis
 Van Winkle, A. Jr., Valparaiso
 Vietzke, Paul C. F., Valparaiso
 Weber, Jos. G. S., Maj., M. C.,
 Camp Atterbury
 Wyatt, J. L., Ft. Wayne
 Acker, R. B., South Bend
 Adair, Fred L., Chesterton
 Albrecht, J. R., Washington
 Barnett, Wm. E., Major, M.C.,
 Logansport
 Bartholomew, A. C., Ft. Wayne
 Birmingham, P. J., South Bend
 Bosenbury, Charles S., South Bend
 Brubaker, Ora G., North Manchester
 Bullard, Mattie J., Gary
 Bunker, Ladoka F., N. Manchester
 Burke, Homer L., Bremen
 Catlett, M. B., Ft. Wayne
 Collett, George A., Crawfordsville
 Cook, G. M., Hammond
 Crimm, Paul D., Evansville
 Weeks, P. H., Michigan City
 Weirich, Charles I., Butler
 Weiss, Henry G., Evansville
 White, I. D., Clinton
 Williams, Bernice Morris, New Haven
 Wilson, James L., South Bend
 Yoder, A. C., Goshen
 Burns, Paul E., Montpelier
 Cameron, Don F., Ft. Wayne
 Campbell, John A., Indianapolis
 Carter, O. E., Indianapolis
 Chen, K. K., Indianapolis
 Wolfstein, Isabel J., Indianapolis
 Wyatt, Fred H., Evansville
 Yung, J. R., Terre Haute
 Teeter, E. J., Indianapolis
 Wilhelm, Agatha, South Bend
 Williams, Charles D., Indianapolis
 Wood, Amelia T., Muncie
 Young, G. M., Gary
 Brown, John Stanley, Carlisle
 Brutsch, W. L., Indianapolis
 Bulson, Eugene L., Ft. Wayne

THE WARTIME SERVICE PROGRAM OF THE MATERNAL HEALTH LEAGUE OF INDIANA*

CAROLINE M. GOODWIN, M.D.*

INDIANAPOLIS

War brings the attention of all thoughtful citizens to the social ills of the world. Our own domestic social problems are intensified by the strains and stresses of war. We are alarmed by the rise in juvenile delinquency, by hasty war marriages, rising divorce rates, spread of venereal disease, increase in abortions, and the mental crack-ups that show up increasingly.

Judges, ministers, physicians (particularly our psychiatrists), nurses, social workers, teachers and other important groups discuss the causes and prescribe many and various cures for such social ailments. All these specialists reiterate that the strengthening of the family unit is the basic need today.

The way of life in our democracy is based upon the strength of our family unit. Thus, the father and mother who have good physical and mental health, rearing a family of well-balanced children, are the keystone of our country. It is also true that often the lower-income homes provide that emotional security which is the greatest asset of family life. But our country is not a Utopia, and today we are concerned about the poorly-adjusted families that contribute to our various social problems.

There are hundreds of agencies, public and private, whose work is dedicated to help these families. The most fundamental program in this field is that of planned parenthood. The aim of the National Planned Parenthood Federation is "the safe birth of physically and mentally normal children in a number consistent with the wishes and intellectual and social capacities of the parents, these children to be so spaced that they will have the best likelihood for maximum development, and their mothers will have the opportunity for physical and emotional convalescence between births." Affiliated with the national organization is the Maternal Health League of Indiana, which for ten years has been promoting sound family life.

In reviewing the progress made in the last few years, one should keep in mind that only twenty-five years ago there were no clinics, no teaching, no articles, no books; medicine had not awakened to this physical and mental health problem; public opinion was just beginning to be aroused.

Today there are eight hundred clinics in the United States which are affiliated with the National Planned Parenthood Federation. Sixty per cent of the medical schools include the teaching of child spacing in their obstetrics course; there are hun-

dreds of books and thousands of articles on the subject. Doctors recognize the planned parenthood programs as vital to sound maternal health. The American Medical Association has endorsed planned parenthood as a health measure and has urged research in this field.

Today public opinion is overwhelmingly in favor of family planning. The 1943 *Fortune* magazine poll showed that 84.9 per cent of the women believe that knowledge of birth control should be made available to all women. And in 1944 only two states, Massachusetts and Connecticut, forbid clinics or any contraceptive advice by any practicing physicians for serious health reasons under the old Comstock laws.

Seven states include family-planning clinics in their public health departments' maternal and infancy programs, and these states show a decrease in their maternal death rate. Alabama, for example, had sixty-three deaths per one thousand deliveries in 1938. These figures dropped to thirty-eight deaths per one thousand deliveries in 1942. Family planning was included in Alabama's health program in 1939.

Industry all over the country is seeing a need for family counseling for the millions of women who are working in war jobs. Every married woman who works outside the home needs a completely rounded maternal health program which includes the spacing of children. Thousands of ministers feel that marriage counseling is an important part of their duty. Today millions of wives of service men wish the privilege of making a choice of how many children they can care for until the service men return from war.

Dr. Karl Menninger says in his latest book, *Love Against Hate*, that "... planned parenthood is an essential element in any program for increased mental health and for human peace and happiness."

Today the program of the whole National Planned Parenthood Federation is family planning, not birth control. Promotion of fertility clinics and research is an important part of the work. Since 10 to 15 per cent of all marriages are sterile, and since one-third of these are curable, there is a real need for this program.

The Indianapolis Maternal Health Clinic is one of the eight hundred clinics in the United States. Many of the clinics are in hospitals or are in the same building with other city clinics. At Johns Hopkins the contraceptive clinic is conducted next door to the prenatal clinic. The Indianapolis clinic is an extramural clinic, set up with the high standards of the National Planned Parenthood Federa-

* Reprinted from *Public Welfare in Indiana*, April, 1944.

tion, with an advisory committee of doctors and a board of directors to administer the business. It is a voluntary, nonprofit organization.

Patients are referred to the clinic by doctors, nurses, social workers and by other patients. When a new patient comes in, a careful history is taken by the nurse, who also fully explains the method. Then the patient is examined by the doctor.

Clinic prices on supplies are very low, because of the national organization's arrangements for the eight hundred clinics. Those who cannot pay anything are given the same service as those who can pay the minimum fee of one dollar. A graduated scale up to five dollars maximum has been worked out on a basis of the weekly income and the number of dependents.

The very first patient of the Indianapolis Maternal Health Clinic in December, 1933, was a blind woman with five children, three of whom were also blind. To aid the blind, the National Society for the Prevention of Blindness is interested in a current project in Indiana through which one of the pamphlets of the National Planned Parenthood Federation is being written in Braille. The Maternal Health League of Indiana, in making this Braille booklet available to the state, hopes to help sightless persons in the state who need information on family planning.

After ten years of maternal health work in the Indiana clinics, we see concrete results in the steady stream of patients who have healthy, wanted babies. Their quiet confidences are given to us over and over again: of how freedom from fear has steadied their marriage, of how the spacing of their children has brought them financial ease, and what great pride and delight they have in each wanted child. A poor mother of five children, who had seventeen abortions before she became a Maternal Health Clinic patient, tells us how much this service means to her.

Not the least among clinic services is marriage counseling, not only with the young women of today

who decide to ask for sound information about marriage and thus start their new relationship on a firm basis, but with the hundreds of older married women who are frustrated in their marriage relationship. Marriage counseling is much needed today since in the minds of young and old there is still so much superstition, ignorance and false information.

We know that the services of our clinics strengthen the family unit, for we see examples and hear their stories at every clinic session.

About five thousand patients have used the Indianapolis clinic in the last ten years. Add to this the figures of the South Bend, Fort Wayne and Evansville clinics and the patients referred to private physicians in counties where we have no clinics, and you realize that this essential health program is reaching only a very few people in Indiana. We cannot over-emphasize the importance of planned parenthood in saving the lives and health of mothers and babies. Mothers with cardiac disease, tuberculosis, diabetes and renal disease are almost always poor pregnancy risks. Statistics about death rates for mothers and infants show a sharp rise after the fifth pregnancy. A space of two or three years between babies also means sound maternal health. Freedom from fear, which means everything to mental health, is even more important to the mother's health and to the family unit.

In other states we see the foundation for this medical health service begun in the medical schools. Planned parenthood is part of the program of state and regional conferences on public health, on social hygiene, on industrial hygiene, and on preventive medicine and mental hygiene. The public looks to the medical profession for leadership in this field as in all health programs. Public opinion itself is alive to this need today in Indiana.

For Indiana to be as backward as it is in the recognition of the importance of the planned parenthood program is a tragedy.

Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

INDIANAPOLIS

October 3, 4 and 5, 1944

PIONEER PHYSICIANS AND SURGEONS OF MONTGOMERY COUNTY, INDIANA

GEORGE T. WILLIAMS, M.D.

CRAWFORDSVILLE

(This is a continuation of the article published in the May, September and November, 1943, issues—Editor's Note.)

WAYNE TOWNSHIP

The year 1822 shows the first records of settlers in Wayne Township, and William B. Crooks, M.D., as the first physician. Subsequent physicians were: Drs. Evan Berry, Samuel John Green, James Berry, Marquis L. Bass, Jordan S. Steele, Talmadge, James Hipes, William J. Hurt, Albert N. Hamilton, Alexander P. Fitch, J. S. Claypool, William F. Thompson and Dudley Culver.

William B. Crooks, M.D., was born near Hamilton, Ohio, in February, 1803. He and his wife and two children went to Parke County in 1826, coming to Waynetown in 1830. In the spring of 1834 he moved to Michigan City, Indiana.

Samuel John Green, M.D., was born in Washington County, New York, January 4, 1817. He began the study of medicine in Cambridge, New York, at the age of eighteen; studied medicine for three years—one course at Castleton, Vermont, and two at Jefferson Medical College, Philadelphia, where he graduated in 1838. After his graduation his father gave him a small amount of capital and a horse which he rode from Cambridge, New York, to Crawfordsville, Indiana, arriving in 1839. In 1842 he began the practice of medicine at Waynetown and for over thirty years had an extensive practice. After he started practice in Waynetown he made two trips on horseback to Cincinnati, Ohio, to purchase medicines for his practice. After his retirement he looked back over a long period of usefulness and labor in a country which he had seen changed from a woody wilderness to a garden of beauty and civilization. His health failed and he moved to Ocala, Florida, where he died December 25, 1894, and was buried there.

John William Berry, M.D., was born in Montgomery County, Indiana, September 13, 1855. In 1877 he graduated from Miami College of Medicine and practiced a short time with Dr. A. N. Hamilton. He died in 1881.

Jordan Samuel Steele, M.D., was born in Shelby County, Kentucky, October 4, 1833. He was of the old school of Allopathy, although he did not graduate from any school. He read medicine with Drs. De Pew and Hyten of Danville, Indiana, for four years, and was associated with Dr. William Matthews for two years. In 1860 he came to Waynetown and practiced there the remainder of his life. He died in 1873.

Albert N. Hamilton, M.D., was born in 1847 and died in 1926. At the age of eighteen he began the study of medicine with Dr. James McClelland, later graduating from Miami Medical College. He was

a typical "old family physician" and enjoyed the perfect confidence of the community where he practiced. This is attested by what was said of him on his funeral occasion:

"May the work that Doctor Hamilton has done go on and on until the hour when o'er the low Judean hills there bursts the golden light that heralds the coming of a better morn to all of us who are left behind."

William F. Thompson, M.D., was born in Montgomery County, Indiana, in 1852 and died at Waynetown, Indiana, in 1928. He graduated from The Cincinnati Medical School and practiced a short time in Waynetown where he was associated with Dr. Hamilton. He later became a druggist, which profession he followed for many years, later retiring to the old pioneer home of his father where he spent the remainder of his life.

William Johnson Hurt, M.D., was born on a farm near New Richmond, Indiana, October 22, 1850. He died at Waynetown, Indiana, October 8, 1919. He taught school when a young man. Later he entered Rush Medical College from which he graduated in 1873. He first located at New Ross, later moving to Waynetown, Indiana, where he resided until his death. Dr. Hurt was a man of fine personality and enjoyed the patronage of a large clientele. His son, Dr. Paul T. Hurt, is located in Indianapolis where he is one of the younger generation of physicians located in the Hume-Mansur Building.

Ephraim M. Fine, M.D., was born June 13, 1844, and died May 17, 1903. He graduated from the Ohio Medical College in 1872. He first located at Sterling for a short time, then moved to Steam Corner about 1872 or 1873. In 1892 he located at Veedersburg, remaining there until his death. He had a large practice in Fountain and the western part of Montgomery counties. His picture in our collection, showing him astride his favorite horse, "old Nell," shows the saddlebags carried by the pioneer physicians, also the martingales and hitch rein on the bridle.

CRAWFORDSVILLE AND UNION TOWNSHIPS

Crawfordsville was made the seat of government of Montgomery County, Indiana, and the original plat was laid out March, 1823. In a work entitled "Early Settlers," by Sanford C. Cox of Lafayette, Indiana, compiled from a diary of his experiences and travels in the years of 1824 and 1825, he speaks of Crawfordsville as follows:

"Crawfordsville is the only town between Terre Haute and Fort Wayne.

"Drs. Thomas N. Curry and Magnus Holmes are the only physicians, succeeding a Dr. Yeaman who was the first physician known to have located here."

In the early thirties we find Drs. Henry T. Snook and Israel G. Canby; in 1835, John J. Sloan, M.D.; in 1839, Drs. Winton, Norton and Trembly. In the forties, Drs. S. W. Bennage, Joseph Allen, James Tichnor, Oliver P. Mahan and Thomas W. Fry. Milton Herndon, M.D., was located here at an early date too.

As stated above, Magnus Holmes, M.D., was located here in 1824 and 1825, and on his memorial in Oak Hill Cemetery we find that he was born in 1801 and died in 1846. There is no other data found concerning him at this date. On the Holmes family lot there is a marker bearing this inscription: "George W. Holmes, M.D., 1841-1910." Dr. Warren Ristine of our city informs me he was the son of Magnus Holmes, M.D., but spent his professional life in Iowa, never having practiced in Crawfordsville.

Henry Tidd Snook, M.D., was born near Trenton, New Jersey, July 6, 1798. He became an orphan when very young, and was cared for by his uncle, Henry Tidd. He received his education and studied medicine with his uncle, who was a very prominent doctor for his time. He commenced practicing medicine at Piqua, Ohio, in 1817; then he moved near Cincinnati until in the thirties when he located in Crawfordsville, Indiana. He was a very successful physician. He served two terms in the Democratic legislature and participated in the state convention of 1851. He departed this life November 12, 1856.

Israel G. Canby, M.D., came here in the early thirties. It is said that he was finely educated and was a graduate of an eastern college. November 6, 1835, the records show that he made an addition to the city of Crawfordsville of fifty-eight lots lying south of what is now Wabash Avenue and known as the Canby Addition. April 27, 1836, Dr. Magnus Holmes also made an addition of twelve lots, known as the Holmes Addition.

Simon W. Bennage, M.D., came to Crawfordsville in 1847. He was aggressive and soon had an extensive and remunerative practice. He sold out to Dr. P. M. Layne in 1855 and moved to Marionville, Missouri, where he died some years later.

John Jay Sloan, M.D., was born in 1811 and died in 1883. He located in Crawfordsville in 1835 and enjoyed a large practice. He was a physician of the old order. He was a graduate of Jefferson Medical College, Philadelphia. He had the honor to serve as the *first president* of the Montgomery County Medical Society.

Very little is known of Oliver P. Mahan, M.D., except that he is listed as one of the five physicians from Crawfordsville admitted to membership after the formation of the State Medical Society on June 7, 1849.

Thomas W. Fry, M.D., first practiced in Crawfordsville at the time of the organization of the Indiana State Medical Society and was accepted to

membership on June 7, 1849. He later moved to Lafayette where he died in 1873. He was one of eight men from Montgomery County who made a signal Military Record, being a lieutenant colonel in the Civil War.

James Tichnor, M.D., was in Crawfordsville about 1848 and was admitted to membership in the State Medical Society June 7, 1849. He had an office in a small brick house on the corner of Wash- in 1839, Drs. Winton, Norton and Trembly. In the ington and Spring streets. He later moved to another location. Part of his family rest in our Old Town Cemetery.

Joseph Allen, M.D., was in Crawfordsville in the forties, as he was one of the five physicians from the city to be admitted to membership in the State Medical Society, June 7, 1849. The records show that he was a surgeon in the Union Army.

James G. McMechan, M.D., was born in Cincinnati, Ohio, July 24, 1808. He received his primary education at the district school and afterward spent two years at Oxford, Ohio. He studied medicine with Dr. Winton of Crawfordsville, afterwards attending lectures at the Louisville Medical College. In 1840 he began the practice of medicine in Crawfordsville. In 1852 he graduated from Rush Medical College. In September, 1852, he had a professional card inserted in the *Crawfordsville Locomotive* which read, "I will give my undivided attention to all professional calls. Residence on Washington Street second door South of Jefferson Street. Office at Ott's New Drug Store." In 1866 he located at Dayton, Indiana, and in 1870 moved to Darlington, later returning to Crawfordsville where he died in 1899. Dr. McMechan helped erect the first college building in Crawfordsville and was intimately connected with the early life of the city, having served on the City Council. He was a surgeon in the Army during the Civil War, being present at the battles of Shiloh and Vicksburg.

Samuel B. Morgan, M.D., was born in Huntington County, New Jersey, in 1813. When he was four years of age his parents came to Butler County, Ohio. When but a stripling of a youth he was left an orphan and had to depend upon his judgment and resources. At the age of seventeen he went to Piqua, Ohio, and began to teach school and study medicine. He later entered the Cincinnati Medical School, graduating in 1840. In 1841 he came to Crawfordsville, Indiana, where he began to practice medicine. In 1869 he graduated from Indiana Medical College. In 1871 he met with an accident that crippled him badly for years. He was one of the best known of the pioneer physicians and was very successful. He was a colonel of the 25th Indiana Volunteers in the Civil War. He died in 1886.

Rylan T. Brown, M.D., was born in Lewis County, Kentucky, October 5, 1807. His parents moved to Ohio in 1808, and when old enough to enter school he was sent to the first free school organized west of the Allegheny Mountains. In 1821 he came to Rush County, Indiana, where he acted as guide for

land seekers. In 1826 he commenced the study of medicine at Rushville, Indiana, and completed his studies at the Ohio Medical College where he graduated in 1829. In 1832 he entered into the full practice of his profession at Connersville, Indiana. In 1844 he located in Crawfordsville, where he remained until 1856. Of the coterie of Indiana's brilliant men, in the decades preceding the Civil War, who became prominent in national affairs, the subject of this sketch made his mark in the realm of medicine. In the field of chemistry he attained such proficiency that he was appointed Chief Chemist of the Agricultural Department at Washington, under President Garfield. In 1850 he received from Wabash College the Honorary Degree of Master of Arts. In 1854 he was appointed State Geologist by Governor Wright. In 1858 he was elected to the chair of Natural Science in Northwestern University (now Butler University) and was connected with the University until 1871. He was Professor of Chemistry in the Indiana Medical College during the last two years he was with the University. Dr. Brown was prominent in religious circles, being an able minister of the Campbellite Church. After his retirement he lived quietly, enjoying his books and individual research work, until May 2, 1890, when full of honors and years, like a sheaf fully ripened, he passed on to his reward. He had done a noble work and his career was an enviable one, fraught with great good to humanity.

George W. Dewey, M.D., was born in 1844 and died in 1934. During his entire practice he was located at Dewey's Corner in Union Township, Montgomery County, Indiana. He did a good business and was highly esteemed by the community. He was a gentleman of the old school, the type which is fast disappearing from the profession.

Effie Current, M.D., graduated from the Medical College of Indiana in 1901 and located in Crawfordsville the same year. She was admitted to the Montgomery County Medical Society in 1901, and served as secretary in 1902 and 1903.

James S. McClelland, M.D., was born in Oxford, Ohio, September 3, 1821. He received his literary education in Miami University, Oxford, Ohio, and his medical education with his uncle, Dr. James McClelland, and the Ohio Medical College, from which he graduated in 1850. His first place of residence after graduation was Yountsville, Indiana, with his uncle, Dr. Alfred McClelland. He soon developed that skill in surgery for which he was always distinguished. He later located at Pleasant Hill, Jefferson and Frankfort, Indiana. During the Civil War he enlisted in the 25th Illinois Volunteers, of which he was made Lieutenant Colonel. He was later appointed Medical Director on the Staff of General Sigel in Missouri, and later served as Inspector General of Field Hospitals in Tennessee. In 1863 he received an injury and was mustered out of service. He then located in Crawfordsville and stood high among his fellows as an eminent physician and surgeon. He was a member

of the state society, serving as vice-president in 1853-1854 and 1859-1860. In 1854 he made an extensive report at the state society meeting on "Trembles or Milk Sickness." He passed away August 29, 1875. He was quite a literary man, contributing poems and articles to different weeklies and magazines. The following poem is found in *Beckwith's History of 1881*:

LINES ON MY THIRTY-FIFTH BIRTHDAY

*My years today are thirty-five,
Life's journey half-way o'er,
And as I muse the school boy's laugh
Brings back the days of yore.*

*Telling of careless, merry hours,
In the early morn of life,
Before the heart had callous grown
In its unequal strife.*

*And memory turns her leaves to see
What there may be between
The brown and somber hues of now
And youth's bright field of green.*

*Still, as she turns her leaflets back,
She comes to fading flowers
Laid there, within the folds away,
Telling of sunny hours.*

*But the sunbeams leave a fainter trace,
The clouds a darker hue,
And many a once familiar face
Wears glances strange and new.*

*Dimly she sees a crumbling pile,
Once reared in friendship's name,
Its cherished stones, now many gone,
To pave a path to fame.*

*Embalmed in flowers an altar stands,
Where love's first vow was given.
The cypress at its foot grows green,
Its once fair capstone riven.*

*There pure white roses make their bed,
Where bitter tears have flown,
Aeolian music round its base
Gives low and plaintive moan.*

*The raindrops fall more gently there,
The moon sheds softer light,
And angel voices oft are heard
To mingle there at night.*

*But through the gloom a vision comes,
As bright and green as ever,
'Tis where I prayed at mother's knee.
Long years will dim that never.*

*When thirty-five, through toil and strife,
Has grown to full three-score,
Oh! may I have the faith to kneel
And say that prayer once more."*

(DR. JAMES S. MCCLELLAND)



Military News



From a change-of-address card we learn that Captain E. T. Baumgart, of Indianapolis, is at present in Italy.

After spending a fifteen-day convalescent leave at his home in South Bend, Captain J. R. Caton returned recently to his post at Brownwood, Texas.

Dr. Gilbert Himebaugh, of Indianapolis, has been transferred from Carlisle Barracks to Camp Stewart, Georgia.

Colonel Oliver W. Greer, of Indianapolis, has been transferred from Nashville to Camp Breckenridge, Kentucky.

Formerly at Fort Dix, New Jersey, Lieutenant Lawson J. Clark, of Indianapolis, has recently been transferred to Fort Henry G. Wright, New York.

The new address for Lieutenant J. B. Bennett, of Warren, is Amarillo, Texas. He is with the A.A.F. and was formerly at Lincoln, Nebraska.

Congratulations to Dr. Donald A. Covalt, of Muncie, who has been promoted to a major in the Army Air Corps. He is executive officer to Colonel Howard E. Rusk, the head of the Convalescence and Rehabilitation of the Army Air Corps Medical Corps at Washington, D. C.

Indirect news of Major Carl S. Culbertson, of South Bend, by a colleague stationed near him, gives high praise to the manner in which Major Culbertson has organized his laboratory at the University of Cincinnati Hospital Unit, now stationed abroad, saying it is one of the best.

We extend our congratulations to Dr. Neal Baxter, of Bloomington, who has recently been advanced to the rank of lieutenant commander. Commander Baxter is stationed in the South Pacific, and is serving as flight surgeon with the Naval Air Corps.

We quote from a letter from Captain George Colip, of South Bend, published in the *St. Joseph County Bulletin*, as follows: "Life goes on as usual. Nothing too exciting. We have moved into an old broken-down hotel in town and feel as if it is a palace. We now have hot water, and it is wonderful not to have to heat water in a tin can over a fire to shave."

Major R. L. Hiatt, of Richmond, has been transferred to the Nichols General Hospital in Louisville, having formerly been at Fort Hancock, New Jersey.

Commander W. D. C. Day, of Seymour, has been assigned to the Naval Receiving Station at San Pedro, California.

The latest address for Lieutenant J. Kenneth Jackson, of Aurora, is Camp LeJeune, North Carolina. He was formerly at Columbia, South Carolina.

Attached to the Army's typhus commission, Captain R. A. Elliott, of Gary, is on duty in Italy. Captain Elliott states that with the aid of techniques developed recently by the Army, the work of eradicating typhus has been highly successful.

Dr. D. D. Dickson, of Letts, has been promoted to a major at the Clovis Army Air Base, Clovis, New Mexico. Major Dickson is the base flight surgeon, and supervisor of the Combat Crew Training School.

On May fifth Captain W. E. Jenkinson, of Mount Vernon, reported to Carlisle Barracks for six weeks' training, after which he will receive a permanent assignment at the Starke General Hospital, in Charleston, South Carolina.

Having recently reported to Carlisle Barracks, Pennsylvania, for active duty, Dr. Jack L. Eisaman, of Bluffton, is to be stationed there for the next few weeks, after which he will report to the Tilton General Hospital, Fort Dix, New Jersey.

"Please continue sending *THE JOURNAL*," writes Captain Paul A. Jones, of Lyons. "It is really like receiving letters from home to read of the accomplishments of the Indiana physicians." The latest report is that he now has a New York A.P.O. address, indicating that he has gone overseas.

After serving eighteen months at Pearl Harbor, Lieutenant Commander Joseph H. Stamper, of Middletown, has been transferred to Great Lakes. Commander Stamper reported that he had been there with Drs. William Robertson, of Spiceland; Neal Baxter and Philip Holland, both of Bloomington; William Tindall, of Shelbyville; Jay Overmyer, of Muncie, and Ben Thayer, of North Vernon.

Lieutenant Emory B. Lett, of Loogootee, is now at Colorado Springs, Colorado.

We note that Major Robert D. Fry, of Indianapolis, has been transferred from Camp Wolters, Texas, to Fort Sill, Oklahoma.

Major Robert W. Kuhn, of Wilkinson, is now stationed "somewhere in England."

Lieutenant William B. Ferguson, of Indianapolis, who has been at Carlisle Barracks, is now stationed at Camp Stewart, Georgia.

Captain Jean Pilot, Chicago, is now on duty in the Laboratory of the Station Hospital at Camp McCoy, Wisconsin.

From Captain F. Paul LaFata, of Gary, comes a change-of-address card, indicating that he is now at Kelly Field, San Antonio, Texas.

Captain W. J. Fuson, of Greencastle, who has been stationed at the Air Base Hospital at Rapid City, South Dakota, now has a New York, Army post office address.

After a short leave spent in South Bend, Lieutenant Commander William E. Miller went to Norfolk, Virginia. He was previously stationed in the South Pacific area.

Captain George N. Love, of Connersville, has been transferred to Camp Wheeler, Georgia, from his previous assignment at Little Rock, Arkansas.

Congratulations to Dr. J. S. McElroy, of New-castle, who has been promoted to a major. Major McElroy has been overseas for fifteen months, and since arriving in Sardinia last October he has seen three other Indiana physicians.

Captain L. M. McNaughton, of Petersburg, has sent in a change-of-address V-mail letter which tells that he now has a New York A.P.O. address. His code cable address was given as AMKYAV. Captain McNaughton was formerly stationed at Camp Croft, South Carolina.

Thirty-one young physicians recently graduated from the Indiana University School of Medicine, and now lieutenants in the Army Medical Corps, attended a party and dance held at the Officers' Club at the Walter Reed Hospital, Washington, D.C., recently; this being a Hoosier get-together before they were separated and assigned to scattered units of the Army. After being students together, most of them served in the Medical Field Service School, at Carlisle, Pennsylvania, and later were on duty for six weeks at the Walter Reed Medical Center.

Captain Robert A. Staff, of Rockville, is now stationed in England.

Captain Lee J. Maris spent the latter part of April at his home in Attica. He has been stationed at Los Angeles.

We have received a San Francisco, Army post office address for Captain Milton Omstead, of Petersburg, indicating he has left Chickasha, Oklahoma, for an overseas destination.

Another physician who has gone overseas, following service at Chickasha, Oklahoma, is Captain Norman F. Richards, of Shelbyville.

After spending a short time at his home in Mishawaka, Major W. L. Spalding left April twelfth for duty at Fort Meade, Maryland.

Major C. R. Slick, of Lynn, has been transferred from Camp Robinson, Arkansas, to Camp Rucker, Alabama.

Friends have received word that Captain Howard Stellner, of Pendleton, has landed safely in New Guinea. He is with the 54th General Hospital.

Captain William K. Sennett, of Winamac, is now stationed in Burma. He has been overseas approximately fifteen months, first being stationed in India.

A distinction reserved for few men has been achieved by Lieutenant Colonel Forrest B. Keeling, of Portland, who has been elected president of the Milne Bay Medical Society on the Island of New Guinea. This society is made up of medical officers on duty in the area, and carefully-planned periodic meetings permit exchange of professional experiences in handling sick and wounded personnel under tropical conditions. Colonel Keeling has hereby acquired a real responsibility, along with his duties as commanding officer at an Army station hospital at Milne Bay.

Captain James L. Lamey, of Anderson, is completing his eighteenth month in New Guinea, making him one of the veteran combat zone medical officers of the Southwest Pacific, according to a press release by the GHQ Public Relations Office. We quote: "He first came to New Guinea in November, 1942, with one of the first evacuation hospitals here. That hospital unit handled a large percentage of the American sick and wounded from the Buna-Gona campaign. At present he is assigned to the dispensary at one of the largest of General MacArthur's New Guinea bases." (Incidentally, we shall appreciate receiving Captain Lamey's present address for THE JOURNAL.

A card received from Captain Joseph L. West, of Indianapolis, indicates that he has been transferred from Carlisle Barracks to Fort McClelland, Alabama.

Lieutenant Colonel Edward M. Sirlin, of Mishawaka, is now stationed at Fort Sam Houston, Texas. He formerly had a Minneapolis A.P.O. and had been working in Canada and Alaska.

Word has come to THE JOURNAL office concerning the promotion of Dr. Irvin W. Wilkins, of Indianapolis, to a major. Major Wilkins is now stationed at Scott Field, Illinois.

Major Carl J. Langenbahn, of South Bend, has arrived in England. At present he has his quarters in an old house, along with twenty other physicians, for which they gathered up their own furnishings.

Lieutenant Commander Byron K. Rust, of Indianapolis, has been transferred from the Training School at Great Lakes, Illinois, to the Navy Recruiting Office at Indianapolis.

Recently moved from Fort Knox, Kentucky, Major Alden J. Rarick, of Cromwell, is now on duty at the Ashford General Hospital, White Sulphur Springs, West Virginia.

Lieutenant Colonel Henry H. Reeder, of Jeffersonville, paid us a visit while home on leave the latter part of May. Colonel Reeder is the surgeon for the Armored Replacement Training Center at Fort Knox, Kentucky.

We learn that Captain John R. Phillips, of Michigan City, is now on duty at the United States Naval Training Center, at Great Lakes. Before coming to Great Lakes he had a Fleet post office address.

From "somewhere in New Guinea," Captain Howard W. Stellner, of Pendleton, writes: "I have met several Indiana men, among them being Captain Ake, of Cambridge City; Captain Mallot, of Converse; and Captain Arnold, of Indianapolis. Am still doing psychiatric work."

Lieutenant Commander David A. Morrison, of Kokomo, is in charge of the sick bays on all the ships in his flotilla, and the particular transport to which he is assigned has become one of the most important hospital ships in the Pacific fleet; the operating room is of such interest that both Australian and American physicians spend much of their spare time there as observers. A war correspondent reported that in the recent attack on the Japanese base at Hollandia, Commander Morrison presided over preparations to take the wounded aboard the model hospital.

After being stationed at Fort McClelland, Alabama, Lieutenant Colonel Orval J. Miller, of Fort Wayne, now has a New York, Army post office address.

Major Leonard C. Lund, of Argos, writes as follows: "I am on an island in the combat zone, and have become quite adept at jumping into a foxhole when 'Washing Machine Charlie' comes over or 'Pistol Pete' starts lobbing them over. These steamy jungles are a long way from good old Indiana."

"This is to inform you of my change of address," states Captain Voris F. McFall, of Anderson, who is now serving as flight surgeon for a bombardment group. He further states, "Words cannot express the satisfaction I get out of THE JOURNAL; the news notes about the Indiana doctors that are scattered all over the nation and various parts of the world are just like letters from home. For the benefit of their families and friends, I can tell you that Captain Earl P. Cripe, of Red Key, is a few miles from me with Station No. 18, Air Transport Command; Captain George Balsbaugh, of North Manchester, is with the 828th Engineers; and Captain Eugene Cook, of North Manchester, is also in this bombardment group, but in another squadron. They are all in good shape and getting along as well as any of us with the tropics."

"MedSoc" had the pleasure of receiving an interesting letter from Major John M. Palm, of Brazil, which we take the privilege of quoting:

"I waited until I was in excellent humor before writing. I had a good night's sleep, in spite of a few obnoxious characters with swastikas on their planes who insisted upon prying into other people's business, so I guess it will be safe to write this morning.

"I think that you are doing a good job. I have missed the journals very much and the last two I received I read from cover to cover. Incidentally, those are the only ones I have received since entering service.

"Your letters are very interesting, and although I have only received two, I read the others in THE JOURNAL. I see lots of my old friends are still in there pitching for the 'MED's' and I am happy to note that Indiana, as usual, is out in front.

"From where I sit it seems to me that the most important thing for 'MedSoc' today is to formulate a definite plan for the returning M.D. Three to five years of Army medical practice is going to produce the biggest set-back in the history of medicine in the United States. In spite of hell and high water, the M.D.'s are going to acquire some habits of practice that will be detrimental to them in private practice, especially those men who have been in the field. Those in the hospitals are not going to be much better, although they do get to work with and on (mostly on) patients. I feel sorry for the intern who was inducted without getting a chance

to practice privately. They are going to pick up habits of practice that will stamp them for the rest of their lives, and those boys will be a big problem in regard to regimented medicine when we return. These boys, being younger, are the ones who are out in the field. Our biggest problem in solving so-called 'State Medicine' is in the profession itself. I have come in contact with many M.D.'s who are so far above their financial status in the Army as compared with their earning ability in private life that they are completely sold on the type of work which we are doing. This not only applies to interns but to many of the men who have practiced from five to fifteen years. Those are the men who will cause trouble in regard to regimented medicine.

"Now that I have said my little piece, which I know is not worth the paper it is written on, I will turn to lighter things. Fishing is very good, the weather is lovely, and Major Deutch, from Muncie, has just arrived. Sorry to have bored you, but just wanted to show my appreciation for your work."

From other sources we learn that Major Palm is now in Italy. He has been detailed for several months to instruct French refugee physicians in aviation medicine and physiology, and although he makes no claims for his "French," he enjoyed the work very much.

Following is an excerpt from letters from Dr. Ben Firestein, of South Bend, which we take the privilege of quoting from the *St. Joseph County Service Bulletin*:

"It is still a matter of living underground as much as above the ground. Last night was the first night that I have been able to sleep right through the fireworks. When the noise got loud enough to awaken me, I just rolled over and went right back to sleep. I am sure you would have laughed long and loud if you could have seen me get to bed. Can you imagine anyone crawling into bed with a helmet, an extra pair of socks and a whisk broom? I need the broom to brush off the sand that filters down into my covers when the earth vibrates, and I slip the helmet on when the going gets too rough. It's a 'hell of a life,' but I don't let it get me down. When I feel on the verge of starting a good gripe, I catch myself, for I realize there are others who have it much tougher than I. It will be heavenly to be civilized again. I would be satisfied just to be able to keep my hands clean for a half-hour stretch. I always feel so filthy dirty."

"I don't think there was a more tired person anywhere than I was when I flopped into bed this morning. I was all tired out even before we went on last night. I spent yesterday completing our moving, and that's always a big job. By the time we had all our luggage and gear stowed away, our holes fixed properly, our fire started and our tent blacked out, it was time for supper, and then time for work. We had an especially tough night, all the cases were big ones (that's how it runs

sometimes). By breakfast time we had cleared up everything except one case, and we left that one for the boys coming on fresh from a night's rest. Don't know how much they rested, for it was a particularly noisy night. Usually when we're working we are so engrossed we hardly pay any attention to the racket, and during air raids we don't even stop in surgery, although someone who is not sterile usually comes along and puts helmets on our heads. Kind of gives one a sense of security. Well, anyway, busy as we were, we all heard last night. Had a good big breakfast—hot cereal on which I stirred plenty of fresh butter (our first), canned milk and sugar, good bacon, powdered eggs, and a couple bowls of coffee. Just as I finished and started for my tent, it began to rain—rain, hell, it was a deluge! I was too tired to worry whether my new hole would flood out or not. I undressed and was fast asleep before my head hit the pillow. I slept like a log until three this afternoon. Then I fearfully and with great trepidation examined my fox-hole, and was most pleasantly surprised to find it only damp, not wet. That's a real relief. I'm pretty sure now that if it didn't flood during the heavy incessant rain we had today, it ought to hold up pretty good from now on. I got dressed, shaved, made my bed, and it was time for supper." "It took me two days, even with the help of Pe'pe (my Italian helper), to build my fox hole. I found Pe'pe on the beachhead the day after we arrived, and I can't get rid of him. He chops wood, carries water from the tank to our tent, digs our holes, and any jobs we assign to him. Whatever we give him in pay is accepted with profuse thanks and smiles. My hole is quite the ritziest and most substantial in the area. I certainly worked hard enough on it, and the boys have named it 'Fort Firestein.' I think that once upon a time this was all marshland. One can strike water without digging very deep."

"Bought two eggs from an old washerwoman before we came here. Paid seventeen cents cash for them. Eggs are the diamonds here. The featured rumor at present is that we will have some fresh meat within the next few days. What I could do to a big broiled steak!"

"Our work is still heavy. In fact, we (the team) often do two cases at the same time. I have trained one of the enlisted men to carry on with an anesthetic after I start it for him, and I circulate from one case to another. It works all right."

"It seems that I have spent as much time digging and draining Italian goo as I have in surgery. I've done as much engineering as surgery. Every time it rains I have to retrench the tent, for where I intend to have low spots turn out to be high spots, and the high spots fill in with silt and become higher spots, and the drainage is always the wrong way. We all have the same trouble. There are holes all through the area, some made by nature, some by farmers, and some by shells and bombs. So far, by constant care and attention I have been able to keep my fox hole fairly dry."

News Notes

Dr. J. W. Westra, of Evansville, has moved to Champaign, Illinois.

Dr. Lloyd J. Holliday, who was injured while serving with the United States Navy in the South Seas, has been discharged from the service and has returned to Lafayette.

Dr. W. F. Gessler, of Fort Wayne, was elected president of the Fort Wayne Academy of Medicine and Surgery, at a meeting held on May ninth at the home of Dr. Eugene L. Bulson.

The Indiana State Hospital Association, at its recent meeting in Chicago, elected Dr. Charles W. Myers, superintendent of the Indianapolis City Hospital, as its president for the coming year.

Dr. H. C. Amstutz, who has practiced medicine at Goshen for the past five years, is taking a four-month course in post-graduate work at the St. Alexis Hospital, at Cleveland, Ohio, after which he will enter foreign relief work, and as a representative of the Mennonite Central Committee will be sent to Puerto Rico, India, or China.

Dr. Norman E. Beaver, of Otterbein, and Marjorie Cattle, of Sturgis, Michigan, were married in the chapel of the Tabernacle Presbyterian Church, Indianapolis, on May fourteenth. Doctor Beaver graduated from the Indiana University School of Medicine in April, 1944, and will be stationed at the Marine Base Hospital in San Francisco, California, where they will make their home for the present.

The reappointment of Dr. L. A. Ensminger, of Indianapolis, as a member of the Indianapolis Board of Public Health, has been announced by Mayor Robert H. Tyndall. Dr. Ensminger has served on this board continuously since 1932. One of three members of the health board who was appointed to serve on the newly-created City Hospital Board, he will also serve as a member of that board.

Dr. James R. Montgomery, of Princeton, recently celebrated his fortieth anniversary in the practice of his profession. This date marked a family tradition in the Montgomery family, for when his uncle, Dr. Tom Montgomery, retired from practice at forty years, in 1903, Dr. James and his cousin, Dr. Samuel Montgomery, of Cynthiana, presented him with a gold-headed ebony cane inscribed with the date. When Dr. Sam finished his fortieth year, in 1938, Dr. James added a band to the cane with Dr. Sam's name and date. Now Dr. James' name and date was added to the band by Dr. Sam.

Shelby County reports that its "medical front" has been strengthened by the addition of another physician at Shelbyville, Dr. Victor J. Vollrath, of Indianapolis, having opened an office there.

ANNUAL MEETING OF INTERNATIONAL COLLEGE OF SURGEONS

The ninth annual assembly of the International College of Surgeons will be held at the Benjamin Franklin Hotel, in Philadelphia, on October 3, 4 and 5. The medical profession is invited to attend this session.

According to the *Gary Post-Tribune*, Dr. James P. Bennett, of Chicago, has assumed the duties as chief of the X-ray Department of the Methodist Hospital at Gary. Dr. Bennett was formerly associate roentgenologist at the Cook County Hospital, in Chicago.

Dr. H. E. Parker, who was reported in our columns as having opened offices at Brookston, has informed us that he is still in the employ of the Aluminum Company of America, at Lafayette, and that his Brookston office is open only on evenings when he is not on call at the plant.

UNIVERSITY OF ILLINOIS' REFRESHER COURSE

The University of Illinois College of Medicine announces that its fall didactic and clinical refresher course for specialists in otolaryngology will be held at the college from September 25 to 30, inclusive. Since registration is limited to twenty-five, applications should be filed as early as possible. For further information, write to Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Dr. Frank E. Wiedemann, of Terre Haute, spent the week end of May twenty-seventh at the Rush Medical College, University of Chicago, observing the fiftieth anniversary of his medical career. The celebration took place at a meeting with a group of his former classmates at the college. Out of that class of one hundred sixty-three members, forty are still living. Doctor Wiedemann is reported as being among the first in the United States to make an x-ray machine, and the first medical man in Indiana to make an x-ray picture on a machine made by himself. He has traveled extensively, and in addition to doing post-graduate work in European medical centers has made a number of tours for the purpose of special study in non-medical subjects, such as religion and archeology, having circumnavigated the world several times.

CLASS REUNION

The forty-first annual reunion of the Class of 1903, Indiana, was held at the Columbia Club, Indianapolis, May twenty-first. Twenty-four out of the thirty physicians now practicing in Indiana were present, and with their families the attendance totaled fifty-two. In response to the roll call, the doctors told of their sons or daughters in the armed forces. Letters were read from far-away members, including N. E. Laidacher, of China, Texas; W. A. Moser, of Grant's Pass, Oregon; W. W. Kemper, of Bremen, Ohio; and Robert M. Campbell, of Glendale, California. It was voted to continue annual reunions as long as two members are still alive.

Members present were: Edgar F. Kiser (president of the class), Murray N. Hadley, Kenneth I. Jeffries, Harry J. Weil, Albert W. Miller, and Lewis C. Hicks—all of Indianapolis; E. E. Hamilton, of Dayton, Indiana; F. S. Crockett, Lafayette; D. W. Sheek, Greenwood; E. B. Moser, Windfall; E. F. Kratzer, Kokomo; P. S. Johnson, Richmond; J. E. Cullipher, Elwood; S. C. Wagner, Elkhart; R. H. Wagoner, Colburn; H. M. Shultz, Logansport; J. W. Strange, Loogootee; J. E. Ferrell, Fortville; F. E. Bass, Shelbyville; A. H. Miller, Russia-ville; E. C. Taylor, Evansville; A. C. Newby, Sheridan; W. S. Coleman, Carthage; and Charles N. Combs, secretary, Terre Haute.

INDIANA UNIVERSITY NEWS NOTES

Obstetricians of ten Middle-Western cities who hold memberships in the Central Association of Obstetricians reviewed medical science's latest developments in that field at a meeting held recently at the Indiana University Medical Center and the Indianapolis City Hospital, under the auspices of the Association's Central Travel Club.

The visiting obstetricians from Minneapolis, Duluth, St. Paul, Rochester, Minnesota, Madison, Wisconsin, Milwaukee, Omaha, St. Louis, Chicago and Indianapolis attended lectures arranged by Drs. C. P. Huber and G. W. Gustafson, of the staff of the medical center. Lectures were given by Drs. Gustafson, Huber, John Alex Campbell, D. E. Bowman, C. G. Culbertson, I. H. Page, A. C. Corcoran, and R. D. Taylor, all of Indianapolis.

Dr. Bruce Barnes, of Evansville, had the highest scholastic standing of the one hundred fourteen students who received the Doctor of Medicine degree last month from the Indiana University School of Medicine. Dr. W. D. Gatch, dean of the school, has announced. Dr. Frederick Mackel, of Clinton, ranked second; and Dr. Urban Collignon, of Columbus, third. The following doctors ranked next in scholastic standing: Arnold R. Sanders, New York City; James S. Fitzpatrick, Bloomfield; John J. Reinhard, Jr., Washington; Robert L. Tucker, Fountaintown; Isidore S. Edelman, Brook-

lyn, New York; Robert F. Kimbrough, Logansport, and Ben Wilson, Jr., Bloomington.

Internship appointments for one hundred thirteen members of the recent graduating class of the Indiana University School of Medicine have been announced by Dr. W. D. Gatch, dean of the medical school. Seventy-eight of the young doctors have commissions as first lieutenants in the United States Army, and twelve as lieutenants (jg) in the Navy, and will enter active duty upon completion of their nine-months' internships.

Sixty-four of the internships will be served in Indiana hospitals, forty-three of which will be in Indianapolis. The City Hospital in Indianapolis will have eighteen of the interns; Indiana University Hospitals, 13; and the Methodist Hospital, 12. The Indiana University interns for other Indiana hospitals will be as follows:

St. Catherine's Hospital, East Chicago, 4; Mercy, Gary, 3; St. Margaret, Hammond, 2; Epworth, South Bend, 4; St. Elizabeth's, Lafayette, 3; Lutheran, Fort Wayne, 3, and St. Joseph's, Fort Wayne, 2.

The recently-graduated doctors who are serving their internships at the Indianapolis City Hospital are: Bruce S. Barnes, Evansville; Maurice J. Barry, Jr., Indianapolis; Elmer R. Billings, Washington; Ira L. Faith, Evansville; James S. Fitzpatrick, Bloomfield; Robert L. Gammieri, Indianapolis; William V. Hare, Evansville; Grant C. Johnson, Noblesville; Clement E. Kelley, Indianapolis; Robert F. Kimbrough, Logansport; Harvey D. Lovett, Zionsville; Paul E. McGurf, West Lafayette; Martin J. O'Neil, Indianapolis; Carolyn M. Rawlins, Hammond; John W. Ripley, Jr., Milford; Alfred T. Symmes, Indianapolis; Joseph H. Tuchman, Indianapolis; and Robert L. Tucker, Fountaintown.

The Indiana University hospitals in Indianapolis will have the following interns: Edmunds G. Dimond, Terre Haute; Mrs. Ruth Hepner, Bloomington; Claude D. Holmes, Jr., Lebanon; David M. Jones, Indianapolis; Frederick L. Kiechle, Evansville; Harry A. Ludwick, South Bend; Frederick O. Mackle, Clinton; Maurice M. Manalan, Gary; Hascall H. Muntz, Sylvania, Ohio; Richard J. Reynolds, Bloomington; Harry J. Sacks, East Chicago; William J. Schechter, Indianapolis; and William O. Starks, Indianapolis.

The following will be at the Methodist Hospital in Indianapolis: Edwin E. Gregg, Indianapolis; Robert P. Jay, Kokomo; Glenn W. Irwin, Jr., Roachdale; Robert E. Jenkins, Noblesville; Michael F. McGrath, Indianapolis; Earl W. Sidebottom, Rushville; Paul Siebenmorgen, Terre Haute; Harold R. Tharp, Trafalgar; George S. Westfall, Goshen; Max B. Wills, Anderson, and Fred Houston, Franklin.

The following young doctors from the Indiana University School of Medicine will be located at other Indiana hospitals: St. Catherine's, East Chicago—Marion F. Arnold, Jr., New Palestine; Robert O. Bethea, Jr., Madison; Angelo P. Bonaventura, East Chicago; Henry S. Leviada, Gary. Mercy Hospital, Gary—Charles Baran, Jr., Gary; Norris J. Knoy, Paragon; Richard C. Minczeski, South Bend. St. Margaret's Hospital, Hammond—Robert W. Boswell, Evansville; Robert L. Brown, Evansville. Epworth Hospital, South Bend—Robert D. Dodds, South Bend; Leland F. Downard, Liberty; John J. Farris, Washington; Paul E. Wisenbaugh, North Liberty. St. Elizabeth's Hospital, Lafayette—Joseph McKinley, Delphi; Harold R. Martin, West Lafayette; Marsh H. Smith, West Lafayette. Lutheran Hospital, Fort Wayne—Walter J. Jurgensen, Fort Wayne; Royal G. Meher, North Manchester; Richard B. Smith, New Haven. St. Joseph's Hospital, Fort Wayne—Robert P. Lloyd, Fort Wayne; and Robert J. Schmoll, Fort Wayne.

Six of the Indiana University interns will be at Naval

hospitals, as follows: Frank Bussard, South Bend; Hugh B. McAdams, Boswell; Glenn L. Marshall, Jr., Bloomington; Frank M. Thornburg, Richmond; Wallace R. Van Den Bosch, Mooresville; and Clifford A. Wiethoff, Seymour.

The following will be with the United States Public Health Service: Norman E. Beaver (San Francisco, California), Otterbein; Robert N. Chattin (San Francisco, California), Union City; Bernard E. Flaherty (New Orleans), Indianapolis; Harold B. Houser (New Orleans), North Liberty; Robert O. Lancet (Detroit, Michigan), Indianapolis; Edward J. Swets (Seattle, Washington), Hammond; and Robert L. Witham (Detroit, Michigan), Indianapolis.

Remaining Indiana University medical school graduates will be at the following hospitals: Kenneth L. Cline, Bremen, Grace Hospital, Detroit, Michigan; William L. Colip, South Bend, Rochester (N.Y.) General Hospital; Charles W. Cure, Martinsville, Minneapolis General Hospital; Margaret M. Davis, Clarks Hill, Sacred Heart Hospital, Spokane, Washington; Richard M. Davis, Marion, Philadelphia General Hospital; Merrill T. Eaton, Jr., St. Elizabeth's Hospital, Federal Security Agency, Washington, D.C.; Isidore S. Edelman, Brooklyn, New York, Brooklyn Greenpoint Hospital; Otto T. Englehart, Brazil, Emergency Hospital, Washington, D.C.; Donald T. Foxworthy, Waldron, Cook County Hospital, Chicago; Norman Hasler, Huntingburg, Jersey City Hospital; Charles R. Headlee, Shelbyville, St. Elizabeth's Hospital, Washington, D. C.; Preston S. Houk, Portland, Grace Hospital, Detroit, Michigan; C. Roy Johnson, Jr., Indian-

apolis, Wilson Memorial Hospital, Johnson City, New York; Rex M. Joseph, Indianapolis, Harris Memorial Methodist Hospital, Fort Worth, Texas; Sanford H. Lawrence, Kokomo, Rochester (New York), General Hospital; Ray Lindenschmidt, Evansville, Seymour Hospital, Eloise, Michigan; Merritt C. Mauzy, North Paris, Pontiac General Hospital, Pontiac, Michigan; Harry W. O'Dell, Farmersburg, Jersey City Hospital; Sam Pobanz, Wakarusa, Lutheran Hospital, Eau Claire, Wisconsin; Ronald D. Price, Mount Vernon, Mercy Hospital, Altoona, Pennsylvania; John J. Reinhard, Jr., Washington, D.C., Philadelphia General Hospital; Arnold R. Sanders, New York City, Kings County Hospital, Brooklyn, New York; Dwight W. Schuster, Indianapolis, Jersey City Hospital; Penn-Gaskell Skillern, South Bend, Philadelphia General Hospital; Roger C. Smith, New Haven, Grace Hospital, Detroit; Myron J. Van Horn, Indianapolis, Seymour General Hospital, Eloise, Michigan; G. Kenneth Washington, Gary, Jersey City Hospital; Donald C. Wharton, Fort Wayne, St. Mary of Nazareth Hospital, Chicago; Ben Wilson, Jr., Bloomington, Wayne County General Hospital, Eloise, Michigan; Louis A. Zuckerman, Paterson, New Jersey, Kings County Hospital, Brooklyn, New York; Urban J. Collignon, Columbus, Eloise Hospital, Eloise, Michigan; J. Edmund Deming, Indianapolis, St. Joseph's Hospital, Tacoma, Washington; Robert J. Duffner, Fort Wayne, Good Samaritan Hospital, Cincinnati; Charles F. Gregory, Fremont, Seymour Hospital, Eloise, Michigan; Raymond L. Morpew, Williamsport, Methodist Hospital, Dallas, Texas; and John C. Vanatta III, Brookston, Seymour Hospital, Eloise, Michigan.

Deaths

John Reid Andrews, M.D., of Bedford, died suddenly at his home on May twenty-fifth, at the age of seventy-two. He was a graduate of the Kentucky School of Medicine, Louisville, in 1892.

Robert E. Innis, M.D., of Marion, died at his home on May ninth, at the age of eighty-three. He graduated from the Eclectic Medical College, Cincinnati, in 1886.

Edwin J. Siegmund, M.D., of Wabash, died on May twenty-fifth, at the age of sixty-eight. He graduated from the Chicago Homeopathic Medical College in 1901.

Carrie T. Reid, M.D., of Indianapolis, died at a local hospital on May eleventh, after a prolonged illness. She was sixty-five years of age. She was a graduate of the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1906.

James B. Shoemaker, M.D., of Miami, died suddenly at his summer home in Nevis, Minnesota, on May thirteenth. He was sixty years of age, and had practiced at Miami until last March. He graduated from the Medical College of Indiana, Indianapolis, in 1905. Doctor Shoemaker was a member of the Miami County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

M. B. Van Cleave, M.D., Terre Haute, died at his home on June eleventh. He was sixty-nine years of age, and had practiced medicine at Terre Haute for forty-four years. He graduated from the Hering Medical College, Chicago, in 1900. He was a member of the Vigo County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Lorenzo D. Eley, M.D., of Plymouth, died at his home on May fourteenth, at the age of eighty-eight. He graduated from the College of Physicians and Surgeons, Keokuk, Iowa, in 1896, and established his practice at Plymouth in 1897. He had served as secretary of the county board of health. He was a member of the Marshall County Medical Society, was an honorary member of the Indiana State Medical Association, and was a member of the American Medical Association.

Sidney J. Eichel, M.D., of Evansville, died on May fourteenth, following a two-month illness. He was sixty-seven years of age. Doctor Eichel graduated from the University of Pennsylvania School of Medicine, Philadelphia, in 1898, and had practiced at Evansville since 1900. He had done post-graduate work in Vienna, Budapest, Germany and England. He was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association, and the American Medical Association.

POST-WAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of July, 1919)

B. W. Rhamy, of Fort Wayne, presented an article, "Vaccines and Serums—Their Use and Abuse"; J. S. Nixon, of Kokomo, "Differential Diagnosis of Affections of the Upper Right Abdominal Quadrant"; B. P. Weaver, of Fort Wayne, "Differential Diagnosis between Lesions of the Gallbladder and Stomach"; O. E. Spurgeon, of Muncie, "Premature Alopecia."

Editorially, "Endocrine Dysfunction" was discussed and the second editorial dealt with catgut sterility. (This latter subject was one of much importance in those days, since much comment was being made that too often the catgut was responsible for certain types of infection.)

A move was on foot in the larger medical centers, to "pool" the hospital facilities available for teaching purposes, New York City being the first to broach such a plan.

The editor again reminded his readers that a vacation was a most important thing in the life of a doctor, and advised that some sort of rest from their activities was in order.

The Surgeon General of the Army had been authorized to resume promotion of officers. It was presumed that some physicians, now back in private practice, would benefit by this ruling.

The editor could not refrain from taking another crack at the "Burleson Service," referring to the post office department service, of which he had frequently complained in months past. He specifically referred to a letter addressed to a high-ranking medical officer, stationed in France. After some five months the letter was returned to the writer.

Senator Myers, of Montana, had introduced an anti-vivisection bill in Congress, arousing much comment in medical circles.

Admiral William C. Braisted, of the United States Navy, had been named as president of the American Medical Association for the next year.

Collapse and death from the injection of the arsenicals was being reported from several sections of the country.

The new building of the Indiana University School of Medicine was to be ready for use in September.

American-made salvarsan was now available throughout the country.

The editor discussed the apparent schism then existing between certain groups within the Illinois State Medical Society and the American Medical Association.

It was suggested that the returning medical officers could be of very great service to their local and state medical organizations by disseminating the vast amount of medical lore they had acquired in service; it was predicted that medical organization work would be greatly enhanced by these men.

Four El Paso, Texas, physicians had been dealt with severely by a Federal Court for the part they had played in a huge "dope ring" that had operated in that border city.

The suit of the Jenner Medical College, of Chicago, against the American Medical Association for damages amounting to a half million dollars, and which had been pending for some six years, had been dismissed without trial. The suit originated after the medical group had declared the school to be of too low standard to meet with approval.

The Council on Pharmacy and Chemistry had received a much merited praise for its work in connection with the investigation of numerous drugs and appliances offered to the Surgeon General of the Army for use during the recent war. Many of these materials were found not only worthless, but some of them were extremely dangerous.

It seems that many German physicians had expressed more than a desire to come to America for the practice of their profession, at the close of the war. Several physicians of note had expressed themselves in the matter, the comment of Doctor W. W. Keen, of Philadelphia, being much to the point. He said, "I have thoroughly approved of your recent editorials as to German doctors, who, when peace is declared, are actually proposing to come to America and enter into practice."

Hoosier service physicians, returning to their "home work" were A. R. Kerr, Attica; A. L. Loop, Crawfordsville; H. O. Bruggemann, Fort Wayne; M. F. Porter, Jr., Fort Wayne; and C. E. Cottingham, Indianapolis.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

May 14, 1944

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Present at luncheon meeting: Permanent Study Committee on Health Insurance—W. H. Howard, M.D., chairman; W. U. Kennedy, M.D.; A. C. Yoder, M.D.; Clay Ball, M.D.; A. P. Hauss, M.D.; C. P. Fox, M.D. Jay C. Ketchum, executive vice-president, Michigan Medical Service, Detroit. H. G. Hamer, M.D., delegate to the A.M.A.; J. E. Ferrell, M.D., and A. M. Mitchell, M.D., alternate delegates to the A.M.A. Wemple Dodds, M.D., and B. W. Stocking, M.D.

Membership Report

Number of members May 13, 1944.....	3,186
Number of members May 13, 1943.....	3,009
Gain over last year.....	177
Number of members Dec. 31, 1943.....	3,344

Group Malpractice Insurance

At the last meeting of the committee each member was presented a memorandum prepared by Dr. Nafe. Following a report by Dr. Nafe, the motion was adopted that Dr. Nafe be empowered to negotiate in regard to group malpractice insurance. Motion made by Dr. Oliphant, seconded by Dr. McCaskey.

Dr. Nafe stated that he wanted to prepare a list of questions to be answered before making any agreement with a company to write group malpractice insurance in Indiana.

Treasurer's Office

Dr. Weyerbacher reported that he would be able to give a report at the July meeting of the committee as to the financial standing of the state association at the end of June, 1944, and an estimate of anticipated expenses for the remainder of the year.

Expansion of Office

Letters in regard to stenographic help for the Procurement and Assignment Service, and a request for office rent for the Procurement and Assignment Service, brought to the attention of the committee.

The statements of receipts and expenditures for February and March for the association committees and for April for THE JOURNAL were approved.

1944 Annual Session, Indianapolis,
October 3, 4 and 5, 1944

Letter from Mrs. James W. Baxter, Jr., president of the Woman's Auxiliary, in regard to funds for entertainment, brought to the attention of the committee. The committee felt that the arrangements made by the Council for the duration of the war should stand, and that no funds should be allotted by the association for women's entertainment.

Legislative, Legal and Social Security Matters

National

Status of Wagner-Murray-Dingell Bill.

Bill still in committee. No committee hearing scheduled as yet.

"EMIC" Program.

(a) Report made upon conference in Denver, Colorado, held April 28 and 29, attended by representatives of eight states.

Resolutions against methods used by Children's Bureau brought to the attention of the committee.

General information gained from A. M. A. headquarters is that recommendations will be made to cut down red tape in the "EMIC" program, but that these recommendations will continue the practice whereby the funds are paid to the doctor and not to the patient.

(b) Bulletin from J. W. Holloway, Jr., director of the Bureau of Legal Medicine and Legislation of the A. M. A., in regard to the additional appropriation asked for by the Bureau, brought to the attention of the committee.

Letters from Congressman A. L. Miller, a physician from Nebraska, asking for the removal of the Children's Bureau from the Department of Labor and centralizing health matters in the United States Public Health Service rather than the Labor Department, brought to the attention of the Executive Committee. Upon the motion of Dr. McCaskey, seconded by Dr. Oliphant, the committee recommended Congressman Miller's letters and proposed Bill H. R. 4663 for the study of the legislative committee of the state association.

Public Relations

Reports upon the Public Relations Committee of the A. M. A., the National Physicians Committee, the Western Public Health League, and the Association of American Physicians and Surgeons of the Lake County Medical Society discussed by the committee.

Organization Matters

The committee approved the appointment of the executive secretary as sub-chairman for the medical professions in the Division of Social Forces of the Indiana War History Commission, headed by Clyde E. Wildman, chairman of the Division of Social Forces and president of DePauw University.

Is a man who is on duty with the United States Coast Guard eligible to membership in the state association gratis? Coast Guard medical services are rendered by members of the United States Public Health Service. Suggestion made that this question be referred to Major Glen Lee, asking him for information as to whether such duty would be considered active military duty.

War Medicine

Correspondence in regard to the situation in one county where Procurement and Assignment Service has stated that exorbitant fees are being charged by certain physicians of that county brought to the attention of the committee. Letter received from the county society secretary, saying that the letter from the Executive Committee had been brought to the attention of the censors for investigation. So far no report has been received in regard to the investigation.

State Board of Health

A letter from Dr. Thurman B. Rice, enclosing a copy of the "Plans for the Future Development of the Indiana State Board of Health and the Indiana University Medical Center," was brought to the attention of the Executive Committee. This letter and these plans call for a postwar program covering the following five points:

1. Recodification of Indiana health laws.
2. Reorganization of Indiana State Board of Health.
3. Division of State into health districts on a full-time basis.
4. Construction of new health department buildings.
5. Organization of a School of Public Health at the Indiana University School of Medicine.

Copies of this letter and this program are to be supplied members of the Executive Committee, and Doctor Rice is to be invited to attend the next meeting of the committee.

Letter received from the secretary of a county medical society reporting that "We have had no typhoid deaths in this county following the oral prophylaxis, but we have had two cases sick with typhoid fever after having taken the oral prophylaxis against typhoid."

Letter received asking for any ideas the Executive Committee might have in regard to the "EMIC" program, particularly as to what the attitude of the Executive Committee is in regard to the question "as to whether the men who are receiving a salary at the Coleman Hospital should be paid over and above that received from the state for medical services rendered."

Socialized Medicine

Report received by the committee that the Indiana State Conference on Social Work is to discuss the Wagner-Murray-Dingell Bill at its next statewide conference.

Group Hospitalization and Voluntary

Health Insurance

Report made to committee that a mutual insurance company was in the process of being completed for the administration of a Blue Cross hospitalization plan for Indiana. Guy Spring, formerly of the Cincinnati Chamber of Commerce and formerly connected with the Cincinnati Blue Cross plan, who has been appointed director of the Indiana plan, was introduced to the committee by Albert Stump.

Report of Permanent Study Committee on Health Insurance

The Permanent Study Committee on Health Insurance met previous to the Executive Committee, and Dr. W. U. Kennedy, of New Castle, made the following report to the Executive Committee:

"1. We recommend that the A. M. A. be requested promptly to formulate a basic medical and hospital plan.

"2. Pending an A. M. A. plan, we recommend the adoption of a plan similar to the Michigan plan, including medical and hospital care.

"3. We recommend that our plan be affiliated with a hospital plan.

"4. We recommend that the Executive Committee arrange for the necessary legal base."

Report made by Jay Ketchum upon the Michigan Medical Service.

Mayor LaGuardia has submitted a voluntary, all-inclusive health insurance plan "for all persons, including city employees, who live or work in New York City and earn up to \$5,000 a year," according to an article which appeared in *The New York Times* and which was brought to the attention of the committee.

Industrial Health Conference

Report upon the Industrial Health Conference held in Indianapolis April 19 and 20 showed that the total attendance was 215, representatives from forty-seven firms and organizations being present.

Future Medical Meetings

District Meetings

May 17—Eleventh District Medical Society, Wabash. Dr. McCaskey and T. A. Hendricks to attend.

May 18—Sixth District Medical Society, Greenfield. Dr. McCaskey and T. A. Hendricks to attend.

May 24—Fourth District Medical Society, North Vernon. T. A. Hendricks to attend.

May 24—Ninth District Society, Crawfordsville. Dr. Oliphant to attend.

May 24—Thirteenth District Medical Society, South Bend. (Date changed from May 17.) Dr. Forster to attend.

May 29—Eighth District Medical Society and Woman's Auxiliary to the Madison County Medical Society, Anderson. Dr. Morris Fishbein to speak.

A. M. A. Meeting, June 12 to 16, Chicago

Recommendations for delegates' program:

1. Dr. Homer Hamer, delegate, and Dr. A. M. Mitchell, alternate delegate, discussed various proposed resolutions with the members of the Executive Committee.

2. Recommendations by Dr. George Dillinger, together with a letter from Doctor Asher, and also a proposed resolution from the Vigo County Medical Society calling for the creation of a speakers' bureau by the A. M. A., discussed by the committee. The committee suggested that Dr. Dillinger's resolution and the Vigo County resolution be sent to each member of the delegation for his consideration, and that it be left to the discretion of the delegation as to what resolutions it thought feasible to introduce in the A. M. A. House of Delegates. This motion was made by Dr. Oliphant, seconded by Doctor McCaskey. The committee instructed the secretary to send this material to each delegate and alternate in order that he may have time to consider it before the A. M. A. meeting.

There being no further business, the meeting was adjourned.

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

March 10, 1944

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D.; Mrs. C. F. Voyles and Mrs. W. E. Tinney, representatives of the Woman's Auxiliary to the Indiana State Medical Association, and T. A. Hendricks, executive secretary.

"Measles" and "Whooping Cough" releases, with corrections suggested by pediatricians, approved for publication in papers.

Report on medical meeting:

Feb. 29—Indianapolis Council on CIO, Indianapolis. "Wagner-Murray-Dingell Bill." (40 present.)

Requests for speakers:

Mar. 15—Professional Men's Forum, Indianapolis. "Medical Service After the War."

Mar. 17—Cass County Medical Society, Logansport. "Civilian Defense."

Mar. 23—Vigo County Medical Society, Terre Haute.

Mar. 28—Goshen Business and Professional Women's Club, Goshen. "Wagner-Murray-Dingell Bill."

Mar. 29—Hamilton County Medical Society, Noblesville. Open meeting. "Wagner-Murray-Dingell Bill."

Mar. 30—Wayne-Union County Medical Society, Richmond. Joint meeting with dentists. "Wagner-Murray-Dingell Bill."

Apr. 3—Kiwanis Club, Peru. "Wagner-Murray-Dingell Bill."

Apr. 12—Woman's Auxiliary to the Floyd County Medical Society, New Albany. "Wagner-Murray-Dingell Bill."

Future medical meeting:

Apr. 19 and 20—Industrial Health Conference. Arrangements for program being completed.

The Bureau conferred with representatives of the Woman's Auxiliary in regard to the suggestions of the Special Finance Committee of the Woman's Auxiliary concerning certain changes in the machinery of the Auxiliary. The principal change suggested is that the meeting of the delegates of the Auxiliary be held in the spring rather than in the fall.

The following letter from the Council on Medical Service and Public Relations of the American Medical Association, commending the Indiana State Medical Association, was brought to the attention of the Bureau:

"I am writing to inform you that I have been instructed by the Council on Medical Service and Public Relations to compliment the Indiana State Medical Association and its officers for the fine piece of work that they have done in behalf of organized medicine. The Council feels that your accomplishments have been outstanding and worthy of signal praise."

BUREAU OF PUBLICITY

May 12, 1944

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D.; T. B. Rice, M.D., and T. A. Hendricks, executive secretary.

Reports on medical meetings:

Mar. 14—Kiwanis Club, Greenfield. "Wagner-Murray-Dingell Bill."

Mar. 15—Professional Men's Forum, Indianapolis. "Medical Service After the War." (10 present.)

Mar. 23—Vigo County Medical Society, Terre Haute. "Wagner - Murray - Dingell Bill." Noonday luncheon with Lions, Rotary Club, etc., with 200 present. Evening meeting in Sycamore Hall, Terre Haute Normal School, with 700 present.

Mar. 29—Hamilton County Medical Society, Noblesville. Public meeting. "Wagner-Murray-Dingell Bill." (300 present.)

- Mar. 30—Wayne-Union County Medical Society, Richmond. Joint meeting with dentists. "Wagner-Murray-Dingell Bill." (30 present.)
- Apr. 3—Kiwanis Club, Peru. "Wagner-Murray-Dingell Bill." (100 present.)
- Apr. 19-20—Second Annual Industrial Health Conference, Indianapolis. (215 present.)
- Apr. 20—Commercial Club, Liberty. "Wagner-Murray-Dingell Bill." (75 present.)
- Apr. 21—Postgraduate Ear, Nose and Throat Assembly, Indianapolis. "Wagner-Murray-Dingell Bill." (25 present.)
- Apr. 28-29—"EMIC" meeting, Denver.
- May 8 and 9—Postwar Planning Conference, Indianapolis.
- Future medical meetings:
- May 17—Eleventh District Medical Society, Wabash.
- May 18—Sixth District Medical Society, Greenfield.
- May 24—Fourth District Medical Society, North Vernon.
- May 24—Ninth District Medical Society, Crawfordsville.
- May 24—Thirteenth District Medical Society, South Bend.
- May 29—Woman's Auxiliary to Madison County Medical Society, Anderson.
- June 12 to 16—American Medical Association, Chicago.
- Radio program:
- 14 broadcasts in January.
- 23 broadcasts in February.
- 27 broadcasts in March.
- 27 broadcasts in April.

The Bureau approved continuing the radio programs as a joint effort with the State Board of Health.

Wagner-Murray-Dingell record sent to Chattanooga and Hamilton County Medical Society, Chattanooga, Tennessee.

Advertisement of the Shelby County Medical Society against the Wagner-Murray-Dingell Bill, in the Shelbyville paper, received the commendation of the Bureau.

Three releases on the Industrial Health Conference and one on National Hospital Day approved by the Bureau.

Letter received from the *South Bend Tribune* asking that afternoon papers be given a better break on releases. The Bureau approved dating as many news stories as possible for immediate publication.

Requests for speakers' kits were received from the Council on Medical Service and Public Relations of the American Medical Association, and from a physician in Logansport and one in Bourbon. These requests were filled.

Newspaper clippings reviewed by the Bureau.

BUREAU OF PUBLICITY

June 2, 1944

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D.; J. C. Schneider, Director, Division of Food and Drugs, Indiana State Board of Health, and T. A. Hendricks, executive secretary. Releases, "Summer Check-Ups" and "Time to E-Rat-I-Cate," approved for publication.

Reports on medical meetings:

May 17—Eleventh District Medical Society, Wabash. (50 present.)

May 18—Sixth District Medical Society, Greenfield. (100 present.)

May 24—Fourth District Medical Society, North Vernon.

May 24—Ninth District Medical Society, Crawfordsville.

May 24—Thirteenth District Medical Society, South Bend.

May 29—Eighth District Medical Society and series of meetings sponsored by Woman's Auxiliary to the Madison County Medical Society, Anderson. "Wagner-Murray-Dingell Bill." Luncheon club meeting; public evening meeting. (400 present.)

Future medical meeting:

June 12 to 16—American Medical Association, Chicago.

Radio program for May:

Weekly program over WTRC, Elkhart; WFBM, Indianapolis—Monday.

Weekly program over WKMO, Kokomo—Tuesday.

Weekly program over WOWO, Fort Wayne—Wednesday.

Weekly program over WBOW, Terre Haute—Thursday.

Weekly program over WSBT, South Bend—Friday.

New station, WKBV, Richmond—Mondays at 1:30 P. M.—transcriptions started May 1.

Making eight regular broadcasts weekly.

Special program, Child Health Day, May 2, WIRE, Indianapolis.

Total programs for May—31.

Report made that the Schenley Research Institute, makers of penicillin, is to sponsor the regular weekly radio program of the American Medical Association. Question as to the advisability of obtaining a commercial sponsor for the state association broadcasts discussed by the Bureau. The Bureau felt that it might be well to see the reaction at the A. M. A. meeting to having a commercial organization sponsor A. M. A. radio programs before considering this further in Indiana.

Article in *The Journal of the American Medical Association* regarding "Health Transcription Broadcasting in Arizona" brought to the attention of the Bureau. The Arizona State Medical Association has taken the A. M. A. transcription records

(Continued on page xxiii)

(Continued from page 386)

and has broadcast them along with comments of local interest.

The following letter was received from Chattanooga in regard to the Wagner-Murray-Dingell Bill record that was sent to the Chattanooga and Hamilton County Medical Society in Tennessee:

"It was most kind of you to send me the recordings, which our medical society enjoyed very, very much. I am returning the records. If there is any expense, please let me know and I will send you my check."

The Bureau approved the establishment of a radio broadcasting booth at the annual session of the state association in October. The booth is to be equipped with a recording machine so that transcription records may be used. If possible, one or two radio broadcasts should be arranged direct from the booth.

The Bureau approved the publication of a bulletin to be sent to each member of the profession in regard to the necessity of prescribing for sulfa drugs. This bulletin is to be sent out over the signatures of the Bureau of Publicity. The bulletin was discussed with J. C. Schneider, director of the Division of Food and Drugs of the Indiana State Board of Health. Accompanying it is to be a bulletin from the Indiana Pharmaceutical Association declaring that "The over-counter sale of sulfa and other dangerous drugs is illegal." In this bulletin the physicians of Indiana are urged to cooperate with the Division of Food and Drugs of the Indiana State Board of Health in its enforcement of the law concerning the sale of sulfa drugs.

Letter received from a physician in Rutland, Vermont, thanking the Bureau of Publicity for the speaker's kit.

Advertisement in *The Anderson Daily Bulletin* on the Wagner-Murray-Dingell Bill brought to the attention of the Bureau, along with material against the Wagner-Murray-Dingell Bill that was distributed by "The Credit Bureau, Inc.," of Evansville, Indiana.

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

FORT WAYNE-ALLEN COUNTY MEDICAL SOCIETY:

President, Juan Rodriguez, Fort Wayne.
Vice-president, D. R. Benninghoff, Fort Wayne.
Secretary, Harry C. Harvey, Fort Wayne.
Treasurer, Lawrence Shinabery, Fort Wayne.

HANCOCK COUNTY MEDICAL SOCIETY:

President, Charles Milo Gibbs, Greenfield.
Vice-president, Robert O. Scott, Charlottesville.
Secretary-treasurer, J. L. Allen, Greenfield.

VANDERBURGH COUNTY MEDICAL SOCIETY:

President, James Y. Welborn, Evansville.
Vice-president, George Willison, Evansville.
Secretary-treasurer, Stanton L. Bryan, Evansville.

WHITE COUNTY MEDICAL SOCIETY:

President, J. P. Galbreth, Burnettsville.
Vice-president, H. W. Greist, Monticello.
Secretary-treasurer, H. B. Gable, Monticello.

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MEDICINE—Two Weeks Personal Course in Electrocardiography & Heart Disease starts August 7. Two Weeks Course Internal Medicine starts October 16.

GYNECOLOGY—Two Weeks Intensive Course starting October 2. One Month Personal Course starts August 7. One Week Course Vaginal Approach to Pelvic Surgery starts October 23.

OBSTETRICS—Two Weeks Intensive Course starts October 16.

ANESTHESIA—Two Weeks Course Regional, Intravenous & Caudal Anesthesia.

GASTROSCOPY—Personal Course starts October 16.

OTOLARYNGOLOGY—Two Weeks Intensive Course starts October 2.

ROENTGENOLOGY—Clinical Course X-ray Interpretation, Fluorscopy, Deep X-ray Therapy every week.
UROLOGY—Two Weeks Course and One Month Course available every two weeks.

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Cass County Medical Society members held a meeting in the Cass County Hospital on May nineteenth. Dr. Raymond Rice, of the Eli Lilly Company, of Indianapolis, gave an illustrated talk on the tremendous development in the use of "Penicillin," stressing, however, that it is not a "cure all" for all known diseases. The woman's auxiliary and registered nurses were guests of the society.

Delaware-Blackford County Medical Society members met at the Roberts Hotel, Muncie, on May sixteenth. A discussion was held concerning hospital and medical service plans. Fifteen members attended the meeting.

Floyd County Medical Society members met on May thirteenth at the Francis Cafeteria, New Albany. Dr. P. H. Schoen, of New Albany, spoke on the "Changing Knowledge of Anterior Poliomyelitis." Eight members attended this meeting.

Fort Wayne County Medical Society members held their last scientific program for the year at the Chamber of Commerce Building, on May sixteenth. Dr. Willis D. Gatch, of Indianapolis, was the principal speaker. His topic, "Treatment of Bowel Obstructions," was illustrated with lantern slides.

Grant County Medical Society members held a business meeting at the Marion General Hospital, Marion, on June eighth. A discussion on "T. B. Mass X-ray" was held. Ten members were present at the meeting.

Greene County Medical Society members held a business meeting at the Freeman (Greene County) Hospital, at Linton, on May twelfth. Interesting cases were discussed. Five members were present at this meeting.

Indianapolis (Marion County) Medical Society members held a symposium on "Penicillin," in connection with the medical staff of Billings General Hospital, at the Indianapolis Athletic Club, on May sixteenth. Colonel F. A. Rice, of Billings Hospital, was in charge of the program.

LaPorte County Medical Society members were entertained at Dr. W. W. Ross' Country Lodge, Springville, on May eighteenth, at a dinner meeting. "Recent Advances in Endocrine Therapy," was discussed by Dr. D. C. Hines, of Indianapolis. Thirty-four members were in attendance at this meeting.

Posey County Medical Society members met at the office of Dr. Lewis W. Thompson, of New Harmony, on May twenty-sixth. All seven Posey County physicians remaining at their posts, following the entrance of their professional colleagues into military service, attended the meeting. All the officers of the society being in the service, new officers, all of Mount Vernon, were elected as follows: President, J. William Herr; vice-president, L. John Vogel; and secretary-treasurer, John R. Ranes.

St. Joseph County Medical Society members heard Dr. Augusta Webster, of Chicago, discuss "The Use of Vitamin K in Obstetrics" at a meeting held at the Indiana Club, in South Bend, on May twenty-third. Forty members and guests attended the meeting.

Wabash County Medical Society members held their monthly meeting at the Women's Clubhouse, in Wabash, on May third. The dinner was followed by an interesting discussion of four unusual medical cases—all members participating in the discussion, exchanging ideas on unusual medical problems. Thirteen members attended the meeting.

Wells County Medical Society members held their last meeting for the season at the office of Dr. R. C. Wybourn, of Ossian, on May eighth. This was in the form of a dinner meeting, and the guest speaker was Dr. Samuel R. Mercer, of Fort Wayne, whose topic was "Syphilis." Nine members were in attendance at this meeting.

DISTRICT MEETINGS

FOURTH DISTRICT MEDICAL SOCIETY

The Fourth Councilor District of the Indiana State Medical Association held its fortieth annual assembly at the auditorium of the Jennings County Public Library, at North Vernon, on May twenty-fourth. Physicians from eight Indiana counties were present. Speakers represented on the program were: M. H. Pulskamp, of Louisville, Kentucky; Thurman B. Rice, of Indianapolis; Arthur B. Richter, of Indianapolis; C. E. Gillespie, of Seymour; and discussions were led by H. Graessle, of Seymour; J. C. Elliott, of Guilford; W. S. Fisher, of Columbus; and Fred Denny, of Madison.

SIXTH DISTRICT MEDICAL SOCIETY

The Sixth Councilor District members held a meeting at the Riley Park, at Greenfield, on May twenty-fifth. Major E. H. Burford and Lieutenant William J. Barkley, both of Billings General Hospital, were the speakers of the day.

EIGHTH DISTRICT MEDICAL SOCIETY

The Eighth Councilor District members held their spring meeting at Anderson on May twenty-ninth. The guest speaker was Dr. Morris H. Fishbein, of Chicago, who addressed a luncheon group of service clubs at noon, discussed "Medical and Hospital Insurance" at the afternoon session, and in the evening spoke at a public meeting held at the high school auditorium, under the sponsorship of the woman's auxiliary, expressing his views concerning the proposed Wagner-Murray-Dingell Bill.

NINTH DISTRICT MEDICAL SOCIETY

The Ninth Councilor District members held an all-day meeting at the Crawfordsville Country Club on May twenty-fourth. A clinico-pathological conference was arranged as a part of the scientific program, with Dr. L. G. Montgomery, of Muncie, discussing "Pathology," and Dr. D. C. McClelland, of Lafayette, discussing "Radiology." Cases were presented as follows: "Carcinoid of Ileum," by Dr. R. R. Pollom, of Crawfordsville; "Salmonella Supestifer Infections," by R. R. Pollom, of Crawfordsville, and H. D. Kindell, of New Richmond; "Acute Hemorrhagic Pancreatitis," by G. T. Williams, of Crawfordsville; "Lymphosarcoma of Stomach," by H. A. Kinnaman, of Crawfordsville; and "Osteogenic Sarcoma of Tibia," by F. D. Johnson, of Waynetown. An address on "Lay Domination of Medical Practice" was given by Dr. W. D. Gatch, of Indianapolis. Dr. Theodore G. Gronert, professor of History at Wabash College, was the principal speaker at the banquet, discussing "America's Stake in World Affairs."

ELEVENTH DISTRICT MEDICAL SOCIETY

The Eleventh Councilor District members held their semi-annual meeting at the Women's Clubhouse, at Wabash, on May seventeenth. Three speakers addressed the group, namely: Dr. D. C. Hines, of Indianapolis; J. E. Culp, of Fort Wayne; and Russell Sage, of Indianapolis. Forty-three members attended the meeting.

THIRTEENTH DISTRICT MEDICAL SOCIETY

The Thirteenth Councilor District members held a meeting at Hotel LaSalle, South Bend, on May twenty-fourth. Herman L. Kretschmer, president-elect of the American Medical Association, was the principal speaker, his subject being "Diseases of the Urinary Tract in Women and Children." About fifty members were present at this meeting.

WOMAN'S AUXILIARY
to the
Indiana State Medical Association

President—Mrs. James Baxter, Jr., New Albany
President-elect—Mrs. F. M. Gastineau, Indianapolis
Corresponding Secretary—Mrs. John Habermel, New Albany
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis

ALLEN COUNTY

Mrs. A. C. Worley was chosen president-elect of the Woman's Auxiliary to the Allen County Medical Society at its annual election recently, following a dinner at the Indian Village Pavilion, celebrating the fifth birthday of the organization. Between forty and fifty members enjoyed the meeting.

The following is a transcript of a talk given by Mrs. E. L. Cartwright, over Radio Station WOWO, on March second, for the Red Cross Blood Donor Service:

"Among the members of the Medical Auxiliary we have a number of registered nurses. This group of women and other registered nurses living in Allen County readily accepted the invitation to assist at the Blood Donor Center. Under the chairmanship of Mrs. Harry W. Garton, they have been on duty whenever the center is open, and also have responded to calls at other times.

"In this war the civilian at home, safely and painlessly can shed his blood for his country, under the supervision of the Red Cross. Millions of adults who could not pass an Army medical examination can meet the simple requirements of giving blood—the inconvenience is trifling. Theirs is no sacrifice at all compared with that of the soldier or sailor under fire. Our Medical Auxiliary feels honored to help in any way possible to save human lives."

CLARK COUNTY

The Woman's Auxiliary to the Clark County Medical Society has had several interesting meetings recently. One meeting was held in the morning, when seven members sewed for the Clark County Memorial Hospital. At another meeting Mrs. Allean Weber, superintendent of the Clark County Memorial Hospital, was the guest speaker, and plans were made for a rummage sale. Proceeds will be turned over to the Cancer Control Campaign, and a fund is being raised to provide a living room for the nurses' home.

MARION COUNTY

On May twenty-sixth the Woman's Auxiliary to the Indianapolis Medical Society held a tea at the Methodist Hospital Nurses' Home. The guests reported that it was one of the loveliest affairs given by the auxiliary this season.

Books

BOOKS RECEIVED

THE FIRST BOUND SUPPLEMENT TO THE PHARMACOPOEIA OF THE UNITED STATES OF AMERICA. Twelfth Revision. Prepared by the Committee of Revision, and Published by the Board of Trustees. 104 pages. Mack Printing Company, Easton, Pennsylvania, 1944.

VIRUS DISEASES IN MAN, ANIMAL AND PLANT. By Gustav Seiffert. 332 pages. Cloth. Price, \$5.00. Philosophical Library, New York City, 1944.

A NATIONAL HEALTH SERVICE. By the Ministry of Health, Department of Health for Scotland. 85 pages. Price \$0.75. The Macmillan Company, New York, 1944.

PRACTICAL MALARIA CONTROL. A handbook for Field Workers. By Carl E. M. Gunther, M.D., Field Medical Officer, Bulolo Gold Dredging Limited, Territory of New Guinea, at present with the Australian Medical Corps. 91 pages. Price, \$2.50. The Philosophical Library, New York, 1944.

BOOKS REVIEWED

HANDBOOK OF NUTRITION. A Symposium, Prepared Under the Auspices of the Council on Foods and Nutrition of the American Medical Association. 586 pages. Cloth. Price \$2.50. American Medical Association, Chicago, 1943.

This handbook is a compendium on nutrition, written by the best authors in the land. Seldom have so many authorities of note contributed to such a splendid book. It is refreshing to learn that an adequate diet can be improved so much by applying modern dietetics in the selection, preparation, and serving of food. The chemistry of nutrition is correlated with the physiologic needs of people. Human requirements for carbohydrates, proteins, fats, minerals and vitamins are based upon scientific facts, and the essential foods are suggested to supply them. The reader who has interest in mechanisms of physiology will be impressed with such chapters as those on "Proteins in Nutrition," "Role of Fat in Diet," and "Water and Salts in Diet," and he will become fascinated by the articles on "Iron," "Copper," "Iodine," "Manganese," "Cobalt" and the other "Trace Elements." The dentist will be highly pleased to learn more about "fluorine" and tooth decay. Even the enthusiast over vitamins in nutrition will learn that a well-planned diet may supply all the dietary needs for his patient without having him follow obnoxious "radio advice."

All in all, this is a book that every dietician, physiologist, and physician should add to his library. It concisely brings the science of nutrition to everyone in a simple, clear symposium on the subject.

C. R.

The prevention of disease and the prevention of war are today the two great world problems. The way is pretty plain in this matter of war, be it against a pathogenic microbe or against a pathologic nation of people. As we have organized preventive medicine, we must organize preventive war. In medicine we do not talk about peace with the disease, with the parasites, with the tubercle bacillus, for example. We do not propose to write a peace treaty with these causes of disease. We do not sit around a peace table with our disease-producing enemies. We wage continuously either an active or preventive war. We should have a continuous preventive war program fashioned along the lines of our continuous preventive disease program.—*Diplomat*, Jan., 1944.

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INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

AUGUST, 1944

NUMBER 8

THE RETROCECAL APPENDIX

(With One Case Report)

LIEUTENANT COLONEL WILLIAM C. REED, M.C.*

MAJOR URBAN F. D. STORK, M.C.†

CAMP SHELBY, MISSISSIPPI

The inflamed retrocecal appendix presents a diagnostic problem much more difficult than the usual case of acute appendicitis. The overlying cecum protects the appendix and prevents the examining hand from eliciting the exquisite tenderness found when the inflamed appendix lies free. It also protects the parietal peritoneum from contact irritation, thus minimizing the accompanying pain and rigidity of the overlying muscles and rendering the entire localizing picture either very indefinite or entirely lacking. This is the type case which may easily be overlooked or neglected while other symptoms are being investigated or treated.

The totally retrocecal appendix is the third most frequent position and is present in about 9 per cent of all cases.¹ Early in the course of the disease these patients do not appear ill; they may be up and about, or even at work with an acute inflammation of the appendix in progress. The history in these cases is especially important as the patient usually complains of abdominal discomfort, nausea and anorexia which suggests a beginning appendicitis. However, the localizing symptoms fail to materialize, and this fact alone should arouse the suspicion of the attending physician to the possibility of a retrocecal appendix. As Welborn² points out, "An accurate history is the most important single factor in the diagnosis." The temperature at this stage will usually be found to be normal, or subnormal. The pain, if present, is likely to be dull or aching rather than the colicky

type seen when the appendix lies free. Gastrointestinal symptoms are usually very mild or entirely absent. The most suspicious symptom is pain or discomfort referred either to the back, bladder, or to the external genitalia. Red blood cells and pus cells in the urine are a common finding in cases of acutely inflamed retrocecal appendix, yet this may only serve to confuse the attending physician and lead to delay while the genito-urinary tract is being thoroughly investigated. Pain referred to the bladder, penis or testicle is also a suspicious complaint and is due to the proximity of the inflammation to the ureter, and to the nerves and vessels supplying the external genitalia. Occasionally a severe chill results when an inflamed appendix lies in apposition to the right ureter or the iliac vessels.³ Leukocytosis is not to be considered a criterion in any case of appendicitis and has no significance in this condition except in late cases in which the general symptoms appear mild. With the finding of 15,000 to 30,000 leukocytes per cu. mm. of blood in a patient with only vague abdominal objective findings, the physician should immediately become suspicious of the possibility of an acutely inflamed retrocecal appendix or a retrocecal abscess.

The examining hand will not discover a point of maximum tenderness in these cases, either over McBurney's point or any other point. In fact there may be a surprising lack of pain on pressure over all parts of the abdominal wall. The maximum tenderness and muscular rigidity are posterior but seldom extend as far superiorly as the costovertebral angle. Rectal examination usually adds nothing to the diagnosis as the examining finger cannot reach to the height of the cecum.

* Of Bloomington, Indiana.

† Of Evansville, Indiana.

¹ Spivack, Julius L.: *The Surgical Technic of Abdominal Operations*, pp. 208-211, S. B. Debour, Chicago, 1936.

² Welborn, Mell B.: The Diagnosis of Acute Appendicitis, *J. Ind. St. Med. Assn.*, 37:68, (Feb.) 1944.

³ Christopher, Frederick: *Textbook of Surgery*, 2d edition, p. 1119. Saunders, 1940, Philadelphia.

The differential diagnosis in this condition is more difficult than in the free-lying case because of the possibility of kidney, ureteral, or even gall bladder disease. In ureteral or kidney colic the pain reaches its maximum intensity shortly after its beginning. The pain is out of all proportion to other findings. X-ray examination may clinch the diagnosis if the stone can be demonstrated, although this is not always possible. Pyelitis is characterized by high fever, profuse sweating and chills, which are not usually present in early appendiceal inflammation. However, pus in the urine, lumbar tenderness and dysuria are present to some extent in this form of appendicitis. Atypical gall bladder symptoms also present a confusing picture. When the liver is low or the gall bladder enlarged, the tenderness may be found far down in the abdomen, and, conversely, a long, retrocecal appendix may give rise to pain and tenderness in the right upper quadrant. Occasionally the tip of the appendix will extend superiorly to the level of the gall bladder, which results in a very confusing picture. A history of previous attacks of similar pain and indigestion, especially if they subside quickly, suggests gall bladder disease.

The most frequent and dangerous complication of acute retrocecal appendicitis is subphrenic abscess. When a retrocecal appendix perforates, the infection may extend upward and localize in the right subphrenic space, or it may extend across and localize in the left subphrenic space as well. A septic type of temperature along with x-ray evidence of elevation of the diaphragm gives a clue to this condition.

At operation the right iliac fossa may be searched diligently without discovering the appendix. How is it possible to determine whether or not we are dealing with a retrocecal appendix? Spivack¹ has formulated the following rule which has proved to be very accurate: "If the terminal part of the ileum is attached to the brim of the pelvis, then in 90 per cent of all cases the appendix is retrocecal or retrocolic." When it has been determined that this is the case, the cecum is mobilized and reflected medially, thus exposing the appendix. In a few instances even this procedure fails to reveal the appendix, and it is necessary to grasp the wall of the cecum to locate the appendix and to incise the serosa before it can be demonstrated. In exceptional cases a portion of the appendix will be actually embedded in the wall of the cecum, and if this condition is not recognized only the projecting portion will be removed, leaving the embedded portion of the appendix unremoved and subject to future inflammation. In such cases the entire length of the appendix should be palpated first, then dissected free from the wall by incising the serosa of the cecum on each side of it, and removed in the usual manner.

In removing the retrocecal appendix in the acute stage of inflammation, nothing else should be done,

but in the quiescent stage the operation should be supplemented by mobilization of the terminal ileum, bringing it to its normal anatomical position since this kink predisposes to intestinal obstruction.

CASE REPORT

A twenty-three-year-old colored private with one year and six months' service was admitted to the Station Hospital, Camp Shelby, Mississippi, at 10:00 P. M., September 14, 1943, because of vague abdominal discomfort of three days' duration. The patient was ambulant and had no acute symptoms. The admitting TPR was 98.2, 80, and 16, and a differential blood count was reported as WBC 7,800 with baso. 1, stabs. 1, segs. 40, lymphs. 54, and monos. 4. The patient was admitted to the receiving ward where he spent the night. He was seen by a member of the surgical staff the morning of September fifteenth and was transferred to a ward of the surgical service on his recommendation. After examination on this ward the following note was made: "Onset of abdominal pain three days ago. No nausea or vomiting. There is some pain in the right flank. No previous attacks. Has no gastro-intestinal or genito-urinary symptoms. Tenderness and muscle spasm is present over right flank, posteriorly, on deep palpation." The temperature was recorded as being 99.6 on the fifteenth. On the sixteenth the following note was made: "Patient still has vague pain in right flank with a temperature now of 100 plus. There is tenderness and muscle spasm, posteriorly. Diagnosis: Acute appendicitis."

The patient was operated upon at 10:15 A. M. that day, under spinal anaesthesia, using mety-caine, 150 mgms., dissolved in 3 cc. spinal fluid, administered between the third and fourth lumbar vertebrae. It was necessary to supplement this with gas-oxygen-ether inhalation anesthesia before completion of the operation. The following report was dictated by the operating surgeon at the close of the operation: "Gridiron incision. The appendix was located retrocecaly with the tip at the lower pole of the kidney. The appendix was covered with numerous adhesions, requiring that it be removed retrograde, stripping away the peritoneal coat. The stump was ligated, phenolized and inverted. When the appendix was delivered a perforation was noted in the bulbous portion of the tip. Five gm. of sulfanilamide crystals were placed in the abdominal cavity. The wound was closed in layers, using Ch. #00 throughout, and dermal in the skin. No free pus was encountered in the abdominal cavity."

The pathologist's report on the specimen submitted was as follows: "*Gross:* The specimen consists of an appendix 14½ cm. long and 7 mm. in diameter. In the distal end for a distance of 2 cm. the tip is bulbous, having a dimension of 1½ cm., and the surface is covered with products of inflammation. On section the wall is seen to be markedly thickened. The proximal portion shows

some thickening of the wall. *Microscopic examination:* In sections of the distal end of the appendix, the serosal surface is covered with a thick layer of purulent exudate which is undergoing early organization. The muscle layer is hypertrophied, but in several places it is interrupted and replaced with fat and fibrous connective tissue. The submucosa shows extensive fibrosis and is infiltrated with round cells. A few polymorphonuclear leukocytes are found in the muscular wall. *Diagnosis:* Appendicitis, acute, subsiding; periappendicitis, acute, suppurative."

Following the operation our routine treatment for cases of appendicitis with rupture was instituted. This treatment consists of the administration of oxygen, gastric suction, repeated small blood transfusions, adequate intravenous fluids, and sulfanilamide solution, 1 per cent, by clysis, in such amounts as to keep the blood level of free sulfa at about 8 mgms. per cent. On September eighteenth pneumonia was suspected, but the x-ray was reported as negative. However, on the thirtieth the x-ray reading was: "There is a pneumonic process of the lower portion of the left lung. The whole left lung shows an increased density which is not thought to be due to pneumonia, but may be due to pleural involvement." The chest was checked again on October fourth and the following report rendered: "There is less density in the left chest with definite improvement from the film taken September 30, 1943."

The wound was dressed on September twenty-first, and a large amount of purulent drainage was found. Hot wet packs were applied continuously and the wound was irrigated daily. On October third a specimen of the purulent exudate was sent to the laboratory for culture, and the following report was received: "Non-hemolytic staphylococcus and colon bacillus." The wound continued to drain copious amounts of pus throughout the postoperative course.

A rectal examination made October first revealed a large, hard mass bulging into the rectum. No evidence of fluctuation ever developed, however. Hot rectal irrigations were instituted. The abdomen remained rigid and tender throughout the entire postoperative period. On October sixth about 500 cc. of purulent drainage escaped from the wound. Following this the drainage developed a definite fecal odor and the rectal mass subsided markedly. On October eighteenth there was a large amount of bloody drainage from the wound, in addition to the purulent and fecal discharge. Nausea and vomiting persisted, and on September twenty-ninth severe hiccoughs developed. The patient's condition became progressively more toxic, and about two hours before his death he complained of severe pain in his back and chest, accompanied by labored respirations.

As has been stated, his admission temperature was 98.2. The following day it was recorded as 99.6, and on September sixteenth, the day of opera-

tion, it was 100.6. At eight o'clock the same evening it reached 102. It dropped to 100 the following day, but on the eighteenth it went up to 104.4 (rectal), at which time the pneumonia was suspected but not confirmed by x-ray. However, on the nineteenth the temperature returned to between 100.4 and 101.8. It continued to hover around 100-101 for several days, but on the twenty-second it was recorded as being absolutely normal, 98.6. A septic type temperature developed about this stage of the postoperative course with daily variations from 98.8 to 102.2. On September thirtieth, twenty-seven days before his death, the temperature reached 103.4, which was its highest peak from that time on. During the last two weeks the temperature fluctuated between 98.0 and 101.

Laboratory reports: September 14, 1943: WBC 7,800 with baso. 1, stabs. 1, segs. 40, lymphs. 54, monos. 4. September 17, 1943: WBC 17,700, RBC 5,900,000, hb. 95 per cent; stabs. 11, segs. 77, lymphs. 12. September 30, 1943: WBC 27,500, RBC 4,790,000, hb. 80 per cent; stabs. 3, segs. 61, lymphs. 37. October 1, 1943: WBC 25,400, RBC 4,710,000, hb. 90 per cent; eosins. 2, stabs. 6, segs. 72, lymphs. 20. October 4, 1943: WBC 33,730, RBC 5,730,000, hb. 85 per cent; stabs. 41, segs. 45, lymphs. 13, monos. 1. October 11, 1943: WBC 28,000, RBC 4,960,000, hb. 85 per cent; stabs. 25, segs. 47, lymphs. 28. October 2, 1943: A blood culture was taken and was reported as negative — "no growth after ten days."

The free sulfa blood level was checked repeatedly during the time various forms of sulfa drugs were being administered, with adequate levels being found, varying between 6.7 mgms. per cent and 8.6 mgms. per cent.

Repeated urinalyses were negative.

The Kahn was reported as being negative on admission examination.

SUMMARY OF TREATMENT

The soldier received our routine postoperative care for cases of ruptured appendix. In addition to this, he received a total of 25 gms. of sodium sulfadiazine, intravenously. He received five blood transfusions, totalling 2250 cc. of citrated blood. Fluid intake was maintained throughout the postoperative period at 3000 cc. per day, being administered either per os or intravenously. When he was unable to take normal nourishment by mouth, large doses of multivitamins were administered.

COMMENT

The patient was ill for three days before being admitted to the hospital, and was not operated upon until thirty-six hours after admission because of the lack of definite findings to justify surgical intervention. Preoperatively there was no definite pain or tenderness on examination of the abdomen; there was, however, slight pain and tenderness in

the right flank, but only on deep pressure. Decision to operate was based on the slowly rising temperature and patient's continued complaint of feeling "sick." At operation the appendix was found to be retrocecal, densely adherent, acutely inflamed with a bulbous tip, reaching the lower pole of the kidney. On delivering the appendix it was discovered that the bulbous tip was perforated. While no actual pus was encountered, infection was known to be present and in a very dangerous location. For this reason the patient was immediately given every modern form of treatment at our disposal. In spite of this he eventually succumbed to an overwhelming toxemia, resulting from subdiaphragmatic abscess and widespread general peritonitis. During the postoperative period he apparently recovered from pneumonia, the large pelvic mass subsided following spontaneous drainage of approximately one quart of purulent material from the wound, and a fecal fistula developed. Four different x-ray examinations of the chest made at various stages of the postoperative course failed to suggest the presence of subdiaphragmatic abscess.

The patient expired at 4:20 A. M. October 27, 1943, forty-three days after admission to the hospital and forty-one days after operation.

AUTOPSY REPORT**

Cardiovascular System: Pericarditis, fibrinous;

** Autopsy performed by Alfred Blumberg, Lieutenant-Colonel, M. C., and A. S. Koenig, Captain, M. C.

cloudy swelling, myocardium. Blood vessels, nothing remarkable.

Respiratory System: Effusion, pleuritic; pleurisy, adhesive; bronchiolitis; pneumonia, bronchial; congestion, passive.

Gastro-Intestinal System: Peritonitis, adhesive, purulent; abscess, subdiaphragmatic, staphylococcus non-hemolytic and *Escherichia coli*, right; gangrene, cecum; fistula, fecal, cecum.

Liver: Perihepatitis, mild; cloudy swelling.

Pancreas: Peripancreatitis, pancreatitis (continuity) mild.

Spleen: Perisplenitis, fibrinopurulent; congestion, passive.

Adrenals: Natural.

Genito-Urinary System: Swelling, cloudy, kidneys; ureters, bladder, prostate — natural.

Muscular System: Inflammation, abdominal muscles.

Osseous System: Nothing remarkable.

Cutaneous System: Incision, surgical, right lower quadrant; tract, fistulous, into wound.

Central Nervous System: Not examined.

SUMMARY

1. Cases of retrocaecal appendicitis are atypical, with masked symptoms and confusing findings.
2. The most frequent and dangerous complication of acute retrocecal appendicitis is subphrenic abscess.
3. A case history is presented illustrating the above points.

ABSTRACT

BENEFITS FROM ANNUAL SESSION OF A.M.A.

"Again the American Medical Association has met the challenge by providing the physicians of America with a great forum where they can assemble to speak as a democratic body for the American physician and to strive for those objectives of the Association emphasized by its Constitution: 'to promote the science and art of medicine and the betterment of public health.'" *The Journal* of the Association declares in its June 24 issue in an editorial discussing the 94th Annual Session of the Association, held in Chicago June 12-16. *The Journal* says:

"The wartime session of the American Medical Association, held last week in Chicago, was a remarkable demonstration of the importance of such medical assemblages in the war effort. Unquestionably the morale of the medical profession was improved. New knowledge of medical advancement in the war period was brought to the attention of thousands of physicians who otherwise would have been delayed in bringing themselves up to date. Interest in research was greatly stimulated and the unity of medicine's approach to its social and economic problems was intensified. The attendance, in view of difficulties of transportation and hotel accommodations, was extraordinary, reaching a total of 7,284. . . .

"Once again the House of Delegates established its

leadership by setting forth policies for the American physician which will insure the maintenance of a high quality of medical service, a high standard of medical education and a wider distribution of good medicine to more people. By prompt action relative to medical education, the importance of continuity of teaching and of maintaining an adequate supply of premedical students was emphasized to the nation. Messages were sent directly to all interested government officials and to the Committees on Military Affairs of the House and the Senate. . . .

"The scientific sections throughout the week were attended by capacity audiences. For several of the symposiums and panel discussions the attendance more than taxed the capacity of the halls available. This was particularly true for the symposiums dealing with the use of penicillin, the sulfonamides, rheumatic fever, vitamins and war medicine.

"The Scientific Exhibit functioned throughout the session as a continuous graduate school of medicine. The practical character of the lectures, demonstrations and conferences was enthusiastically commended by those in attendance. . . ."

PSYCHOSOMATIC MEDICINE

JEWETT V. REED, M.D.

INDIANAPOLIS

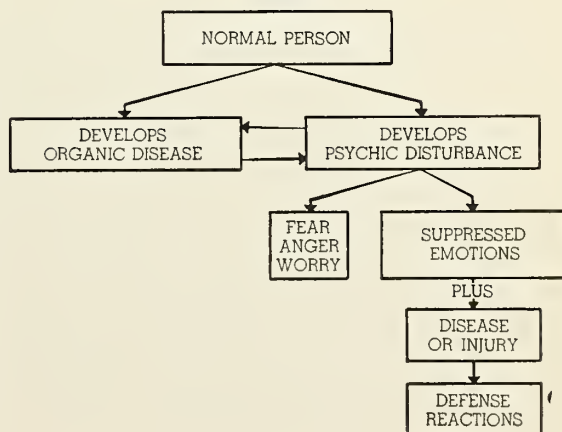
It is probably an anomaly that a surgeon engaged in traumatic surgery should presume to discuss the subject of psychosomatic medicine, but for many years I have been interested in the mental attitude of injured persons and have dealt unconsciously with what might be called "psychosomatic surgery." The literature on psychosomatic medicine, and diagnosis, has grown rapidly and is bringing to our attention this phase of illness, from the medical as well as the surgical standpoint, and I cannot refrain from adding my opinion on this subject, gathered over a number of years' experience.

My conception of psychosomatic medicine is that it is a subject dealing with the relation between various psychic or emotional disturbances and the symptoms arising from organic pathology. This relationship is reciprocal. The primary cause of an illness may be organic, which may be complicated by a secondary psychic disturbance, or the primary disturbance may be entirely psychic, which may result in secondary somatic changes. It is a subject which may explain a multiplicity of symptoms not consistent with the primary organic pathology, and in some cases it may aid us in explaining multiple pathology. It is a fact that almost every person who is ill of an organic disease, and is aware of that disease, experiences more or less emotional reaction. This is true not only of persons suffering from malignant diseases, cardiovascular disease, et cetera, but it is true also of many persons suffering from minor ailments only. This is true also of many injured persons who, in addition to their physical trauma, possess certain emotional factors. It is a common observation that the average injured person shows certain mental reactions to his injury. He may be angry with himself or with the one responsible for his injury; he may be worried, until he feels certain that he will recover; he may be anxious because of financial loss due to his period of disability; and he may become depressed because of a permanent impairment. Such emotional reactions to both disease and injury are perfectly logical and are liable to happen to any of us, but there are other cases in which the patient's complaints are not consistent with his illness or injury, complaints which could not result from the original pathology, and in these cases we are prone to make a diagnosis of neurosis or traumatic neurosis. In my opinion the diagnosis of neurosis is inadequate and very unfair. Fifty years ago appendicitis, peritonitis, intestinal obstruction and all other intra-abdominal catastrophies were diagnosed as "congestion of the bowels." Likewise, meningitis, brain abscess and encephalitis were

classed as "brain fever." In my opinion, when we make a diagnosis of neurosis, neurasthenia and hysteria, we are just as archaic as our predecessors of two generations ago. I have seen many patients who suffered from obscure complaints, who were examined by the most competent internists, who went through the routine of the most efficient clinics and came out with the information that there was nothing organically wrong with them and that their symptoms were due entirely to "nervousness." This leaves them "out on a limb," and another emotion is added to an already existing emotional upset. In present-day practice we cannot suddenly discard the terms "neurosis" and "neurasthenia," but when such terms are used they should not be employed as offering a diagnosis. The diagnosis of neurosis should mean simply that the patient is suffering from one or more forms of functional disturbance, of which there are many. To be complete, the diagnosis of neurosis should specify as nearly as possible the definite form of psychic disturbance present.

The various types of emotions which may affect a person are so numerous that the ordinary physician or surgeon is unable to grasp their significance. Again, many emotions are in close relationship to minor, or even major, psychoses, so in all cases in which the emotional picture is beyond our understanding, or when it approaches a psychosis, our best plan is to call in the help of a neuropsychiatrist or a psychoanalyst. The ordinary physician is not fitted to deal with such emotional disturbances, especially those with a sexual background. There are two types of psychic disturbance, however, that we of the unanointed can handle with a fair degree of success: (Fig. I.) First, the emotions of worry, anxiety, fear and anger. These emotions may accompany or follow

FIGURE I



disease or injury or they may be entirely independent of any primary organic disease, but they may lead to disturbances of physiological function, which if persisted in may lead eventually to organic changes. In the second group are organically normal persons who are under emotional stress which is practically quiescent. Then when an illness or accident occurs, the whole clinical picture of the organic condition is colored by the pre-existing emotional state. These persons develop psychic syndromes which usually can be classed as defense reactions. (Fig. I.)

In considering the emotional reactions of the first group, namely, fear, worry and anger, we have evidence that such psychic states very definitely affect the somatic part of our being. One of the first sets of proof of the effects of emotions on physiological function was given by Pawlow, who in his experiments on dogs with gastric fistulae showed that anger or fright caused a diminution or stoppage of the secretion of gastric juice. This was followed by experiments by Cannon¹ in which he demonstrated by means of x-ray studies on animals which had been given a bismuth meal, that all movements of the stomach and intestines were diminished or caused to cease during periods of anger or fright.

Cannon also demonstrated that under the emotion of anger or fear, laboratory animals showed a decided increase in the secretion from the adrenal glands, which in turn caused a stimulation of the sympathetic nervous system. There occurred also an increase in the amount of blood sugar, an increased muscle tone, an increased pulse and respiration rate and a decrease in the time for coagulation of the blood. The most primitive emotions are anger and fear, emotions that evoke two kinds of bodily activity, either to stand and fight or to run away. Either of these acts requires increased bodily activity, which in turn requires increased energy. This is supplied by the addition of fuel to the muscles in the form of sugar, an addition of oxygen to the tissues by increased heart action and respiratory rate, an increase in muscle alertness with a tendency to a reduction of fatigue produced by the increased adrenal secretion, and to provide for a possible wound there is a decreased clotting time for the blood. All of these physiological changes are reflex phenomena induced by emotions. The above observations made on laboratory animals have been confirmed largely by studies on human beings.

While these physiological reactions to anger and fear are most useful in the preservation of life in animals, and probably also of primitive people, to civilized man they are more of a detriment than a help. Civilized man is constantly being subjected to fear and anger, together with many other unpleasant emotions, and these emotions may be just as intense as in the animal, but in our pres-

ent state of society he can neither fight nor run. He has to work out his problems by means which do not require physical activity but nevertheless the physiological reactions to his emotions are still taking place, such as the diminished flow of gastric secretion, diminished motility of the stomach and intestines, and increased secretion of his adrenal glands. In other words, the body mechanism is tuned-up for speed and endurance, but he goes nowhere and simply "races his engine." Continuous and repeated episodes of this kind eventually lead to definite somatic changes.

Beginning with the depression of 1929 up to the present time, all of us have had plenty to worry about. Fear, anger and apprehension have been our daily diet, and only the most apathetic persons have escaped these emotional reactions while others have been killed by them. I have not studied the statistics on the subject, but I am under the impression that more young men have died of coronary and other forms of heart disease during the past fifteen years than ever before. There is little doubt that hypertension, diabetes, hyperthyroidism, gastric and duodenal ulcer, chronic colitis with its accompanying chronic constipation, and migraine are all on the increase, and in the majority of instances are the result of the emotions of anxiety, fear and anger.

The emotions of fear and anxiety may affect two types of persons: first, the normal individual who under psychic stress, oft repeated, eventually develops an organic disease; and second, the person suffering from a primary organic disease who from worry or anxiety regarding his condition eventually develops a secondary organic disease, causing a multiple pathology.

Fright associated with an injury or an accident constitutes a definite psychosomatic disease entity. Such a condition is often designated a "traumatic neurosis," but the term is too general and in my opinion should not be used because the same psychosomatic features may occur in one who has been in a frightful accident and has suffered no physical injury of any kind. The distressing or frightful circumstances accompanying an accident or injury may so affect the person's emotional state that marked physiological disturbances may result. His memory of the circumstances may affect his cardiovascular, gastro-intestinal and sympathetic nervous system so that he becomes a chronic invalid for weeks or even months.

Examples of horrible or frightful situations which may accompany an injury or accident are as follows: automobile accidents in which the car is demolished, burns, turns over, or rolls down an embankment. If any of the other occupants of the car is killed or mutilated, this will add to the horror of the situation. Similar frightful accidents may occur on trains, street cars, buses, elevators, and on boats. Other horrible situations occur when one is impinged in the debris of a wreck, partially buried by a cave-in of dirt, sand or cement, being trapped in a mine or burning building, involved in

¹ Cannon, Walter B.: *Bodily Changes in Pain, Hunger, Fear and Rage*. D. Appleton and Co., 1920.

an earthquake, flood or tornado, prolonged exposure to the elements, and the frightfulness of battle. We have seen men who have slipped and fallen from high places, caught by their safety belts and left hanging for some time before they could be rescued. These men sustained very minor injuries, but they developed a marked fear reaction that caused disability for several months. A rather common experience is that of a man who has sustained a sub-lethal electric shock. The injury may have been slight and there was nothing frightful about the accident, but as soon as the patient realized that he received enough electric current to ordinarily kill a man, this realization acted as a terrifying factor and caused a true traumatic psychosis.

Persons suffering from fright psychic reactions may show many of the features of frightened dogs of Cannon's experiments, such as rapid pulse, gastro-intestinal disturbance, increased reflexes, sleeplessness and other features of emotional distress. One characteristic feature of these patients is their dread or refusal to discuss their accident.

As noted above, the only forms of psychosomatic disturbances that can be grasped and dealt with by the average physician and surgeon are of two kinds: the first group is due to fear, worry or anger, as just mentioned; and the second group of reactions occurs in persons who are ordinarily normal from an organic standpoint but who harbor an emotional stress that is in a more or less quiescent state. Many persons who are physically normal are under various forms of psychic stresses and strains which they are able to keep subdued and under control. Then when they suddenly are confronted with an injury or an organic disease, regardless of its insignificance or its severity, such an organic condition offers a substantial hook upon which to hang their latent psychic abnormality. Others under the influence of such latent psychic strains are not fortunate enough to sustain an accident or to acquire an organic disease, and as their latent emotion gradually increases to the point where they can endure it no longer, they suddenly develop symptoms simulating an organic disturbance. Such persons are not true malingerers. They have simply "come to the end of their rope," and they unconsciously simulate some disease that is fairly logical, purely as a matter of defense. Such cases in which there is a latent emotional disturbance becoming evident following an injury or an illness, or when the emotion reaches an explosive stage, are usually classed under the term, "defense reactions." Defense reactions following injuries are abnormal mental states accompanied by numerous and bizarre symptoms which are not consistent with the original illness. These reactions are formed in an attempt to escape from one's environment—from problems and situations with which one is unable to cope. In most cases these reactions are directed toward some self-serving purpose, to obtain sympathy, to

better or change one's working conditions, and occasionally to obtain compensation or damages. To escape something that he fears is a common cause. In fact, every emotion, especially unpleasant ones, may be the underlying cause of a defense reaction.

The defense reaction is really a subconscious form of malingering in an otherwise normal and honest person. His desires, either to escape or to obtain the apparently impossible, mould his thoughts and wishes and set the stage for his resulting mental abnormalities. The desire to escape, or the unfulfilled wish in one with this unhealthy mental attitude, may have been present for years, ready to explode, and a trauma, no matter how insignificant, is the percussion cap that sets off the train of defense reaction symptoms.

The person with a defense reaction is seldom confused with anyone except a malingerer, and with experience the two easily can be differentiated. The malingerer is usually self-evident from his gross and inconsistent exaggerations, from his apparent boldness and self-assertiveness. He can usually be led to admit the presence of more and more symptoms, and he usually has an attitude of defiance, as if to challenge the examiner to disprove his claims. The female malingerer usually puts on a better show than the male. She frequently has to lie down as soon as she enters the office. She implores the doctor to treat her gently as she has suffered so much already. She may become faint while being examined, call for water and have to lie down, and still there is no change in color and her pulse remains normal.

On the other hand, the person with a defense reaction will have complaints inconsistent with the injury, but these inconsistencies follow a certain pattern and the patient gives the impression that he is sincere and that he is really suffering. The malingerer is voluntarily dishonest. The defense reaction person may be a subconscious malingerer, but he is essentially honest and really believes in his complaints. He is simply reacting to a desire to accomplish something that he has found impossible to accomplish by any other means. His symptoms and complaints are due largely to what he wishes to believe. To believe what we wish is a trait common to many of us. When unpleasant facts confront us we often refuse to see them and we substitute beliefs more to our liking. A parent, in spite of his suspicions to the contrary, works himself up to the belief that his child is bright, while everyone else knows that he is mentally deficient. The business man whose books show him to be in the "red" may refuse to accept the real figures and continue his business in the old inefficient manner until he finds himself bankrupt. Innumerable examples could be cited in which apparently normal persons persist in believing that which they wish to believe, even if it ruins them. It is this same mental process that evokes symptoms in a person who has suffered an injury, when he sub-

consciously wishes these symptoms to appear. If the subconscious wish is satisfied early, the symptoms usually disappear promptly, but if he is thwarted in the fulfillment of his desire, the symptoms become more and more fixed, often resulting in his becoming a chronic psychic invalid.

The various types of defense reactions may be as numerous and varied as are the human emotions. The most common forms may be grouped under the following headings: faulty environment, intolerable situations, thwarted ambitions, inferiority complex, fear and revenge. It will be noted that the desire for money or for collecting damages is not included in this list. It is true that many unfulfilled desires may be satisfied with money, but in the true defense-reaction person the lack of or desire for money is not the chief emotional factor. However, this may play a secondary role as their emotional complex develops. This is another distinction between the defense-reaction person and the malingerer, for in the latter it is usually very evident from the start that monetary gain is his chief consideration. Two or more of the defense-reaction types may be noted in the same person, one type merging with another.

Faulty environment: An attempt to escape from one's environment is a common cause for a defense reaction. Uncongenial employment is a frequent cause for this type of reaction in workmen who have sustained only a minor injury. The workman may hate his work, his boss, or his fellow workers. From necessity he puts up with these dislikes from day to day, hoping that something may happen to alter his condition. Then when an injury occurs, perhaps a trivial one, it offers an organic condition upon which to hang his subjective symptoms and complaints, which in turn allows him to escape, temporarily at least, from his unpleasant surroundings. Faulty environment may lead to defense reactions in workers who have not had an injury. In such cases the defense symptoms reflect the nature of the work. Occupational spasms and cramps are common, making it impossible for the worker to continue with his job. Workers in intense heat and cold may blame the temperature for their disabling complaints. It has been suggested that miners' nystagmus is a defense reaction to environment in which the worker puts in long hours of heavy labor, in a stooped position, with defective illumination.

Intolerable situations: Situations which to the individual seem hopeless or unbearable are often the basis of a defense reaction. Such situations may be associated with a faulty environment which is intolerable. In an extreme case the situation may seem so hopeless that the person attempts to escape through suicide. In less serious cases he worries from day to day with his problem and is unable to find a solution. Then when an illness or an injury occurs, this for a time relieves him from all responsibility. This respite gives him comfort, and he unconsciously develops a defense reaction in order to escape, for

a time at least, his unpleasant situation. In our experience, those persons who develop this type of defense reaction are very honest and conscientious, and suffer from the fact that they cannot solve their problem or meet their obligations. Inasmuch as few situations are really hopeless, this type of patient is easily cured as soon as we learn the details of his problem and put him on the right track toward solving it.

One of our most interesting and satisfactory cases was as follows: A young girl, a clerk in a department store, presented herself complaining of a severe headache, general nervousness, and weakness following a very slight blow on the forehead from a falling small metal clip. There was no wound or immediate disability. As she appeared quite ill, she was put into the hospital for observation. There the following history was gradually obtained. She had a step-sister who did not work and who had persuaded our patient to allow her to charge articles against her wages. The repayment of these obligations was very slow and caused a constant worry to our patient. One Saturday night she had planned to go to a dance, and needed new slippers. She then found that her entire week's wages had been drawn by the sister, leaving her nothing, and the dance was off. To a young girl, what situation could be more intolerable? Her excuse for not being able to go to the dance was illness, and for a basis for this illness she blamed the slight blow on the forehead of several days before. After diagnosing her psychic trouble and giving her and her family stern business advice, she was well within a few days.

Thwarted ambitions: Very few persons accomplish all that they plan for in their life, but most of us sooner or later realize our limitations and adjust our lives to our capabilities. A few persons, however, start out with high ambitions, work hard and faithfully, but finally recognize that they can never accomplish their goal. Here again the majority accepts the fact and is satisfied with mediocre accomplishments, but there are a few who take the possibility of failure more seriously, and a defense reaction develops. This is especially common among artists, musicians, and those going in for competitive sports. The college athlete who realizes that he cannot hold his own with his fellows develops a painful joint or some other symptom that gracefully lets him out of the coming dreaded game. Musicians whose ambition was the concert stage and who were trained at considerable expense, possibly at a sacrifice of other members of the family, realizing that they could never succeed, suddenly develop an occupational cramp, making it impossible for them to play their instrument. Such a defense reaction, while very disappointing to their friends and family, allows them gradually to revert to an amateur status.

Every occupational cramp or so-called "occupational paralysis," is a psychic protest against that particular occupation.

Inferiority complex: An inferiority complex is a very frequent cause for a defense reaction. It is seen in grade-school children and also in college students. They realize that they are not keeping up with their classmates, so develop a series of defense reactions as an excuse for their failure. The same is true of the business or professional man who realizes that his achievements are far behind his ambitions. In order to justify his lack of success, both to himself and to his friends, he develops defense reactions from the slightest excuse which gives him a justifiable handicap. In this type of person the defense reaction usually takes the form of a nervous breakdown. This type of individual is also prone to develop occupational cramps if his work requires manual dexterity.

Other types of persons suffering from an inferiority complex which may develop a defense reaction are those who are not popular with their co-workers, or those who have some physical handicap or deformity which causes them to be the subject of jokes or unkind remarks. Such persons often develop defense reactions in order to obtain sympathy.

Fear: Defense reactions based on fear must not be confused with the psychic reactions accompanying fearful situations. As mentioned before, there is one type of patient who suffers a severe psychic shock because of some fearful or horrible circumstance accompanying an accident. The fear defense reaction, on the other hand, occurs in persons who have not been through such a terrifying circumstance but who fear that something may happen to them in the future. A common example is seen in workmen employed in hazardous occupations. They have seen a fellow workman injured, and they dread a similar injury to themselves. Such a person may receive a minor injury, which is followed by a set of defense reaction symptoms which prevent or postpone as long as possible his return to that work. When this defense is recognized, it is usually easy to cure the condition by changing or modifying his occupation.

Many persons fail to recover in the usual time required for that particular type of injury. They complain of pain, weakness, impaired sensations, et cetera, which at first may be puzzling, but after a careful study of their mental attitude it is found that they are suffering from a defense reaction because of fear of using the part too soon. This is especially true in the case of fractures in which they fear that the bone will break again. Patients who have suffered fractures and severe sprains of the foot, ankle or leg, requiring the application of a cast, experience swelling of the part when the cast is removed. In such cases active use of the part is the best form of treatment, but because of the swelling the patient fears to use the leg and develops a fear reaction that is sometimes very difficult to overcome.

One type of fear-defense reaction which we believe is quite justifiable is in the person with a

bony cranial defect resulting from a cranial operation or from a compound fracture of the skull. The patient can see and feel the pulsating brain beneath his scalp, and his chief concern is to protect this soft spot in his head. Many of these persons develop fear-defense reactions which keep them within the shelter of their homes. Some develop an atypical form of Jacksonian epilepsy that prevents them from all social and economic contacts. In all of our cases of this kind the fear reaction, including the attacks, ceased as soon as we had accomplished an osteoplastic repair of the defect. In none of our cases was the dura opened or the cortex disturbed, which makes us believe that the seizures were entirely functional rather than due to any organic brain lesion, such as adhesions. It is the advice of some neurosurgeons that all depressed skull fractures be elevated in order to prevent later epileptic attacks. I have never elevated a depression which was not over the motor area of the cortex, and to date have never seen one of them develop epileptic attacks. I have a very strong conviction that all cases of epilepsy following head injuries, the injury not involving the motor cortex, are in reality defense reactions. One of my neurosurgical colleagues has even gone so far as to assume that all cases of idiopathic epilepsy are defense reactions, and from the entire absence of organic findings in such cases there is much to be said in favor of this idea. In all cases of fear-defense reaction, there is the possibility of real somatic elements entering the picture, as fear, worry and anxiety may set up the same train of physiological reactions as described by Cannon.

Revenge: Revenge as a basis of a defense reaction generally presents a very vicious clinical picture. One may be injured because of the carelessness of another, and this carelessness makes him very angry and he wants to get even. Inasmuch as it is not proper in genteel society to fight it out, the victim takes the only course possible—that is to sue the one responsible. The lawsuit is not so much to collect damages as it is to get even. The revenge complex person is suffering not only a defense reaction but the anger accompanying his feeling for revenge may induce certain somatic changes.

An interesting example of revenge-defense reaction is as follows: A maiden lady of middle age made her living making dainty white burial dresses for young female corpses. She took great pride in her work and always inspected it just before the funeral. On one occasion, as she was leaning over the casket to arrange a frill, an attendant passed by and struck the lid of the casket, causing it to fall, and in falling it struck the dressmaker on the head, forcing her face against the body of the corpse. Attendants rushed to her aid, and she said that she was not injured but expressed great anger over the incident. About two weeks later she brought suit against the undertaker because of the injury she had sustained.

Examination showed many of the features of paralysis agitans, which she claimed appeared immediately after the accident. She also showed great indignation. Under ordinary circumstances paralysis agitans most probably would have been the final diagnosis, but this disease does not follow trauma, neither does it develop so rapidly under any circumstances. A private investigation was conducted and it was found that she was perfectly consistent, that her symptoms continued even when she did not know she was being watched. This fact put her out of the class of malingerers. Further investigation showed that our patient had an old aunt who had been a sufferer from paralysis agitans, which in her opinion was the result of a head injury, which circumstance gave our patient an excellent pattern from which to copy. After satisfying her revenge by obtaining moderate damages her symptoms disappeared entirely.

The most hopeless type of revenge-defense reaction is that of the wife who wants to "get even" with her husband. He may drink too much, stay out at night, or do many things of which she does not approve. All persuasion is of no avail, so she has a minor injury or illness from which her reaction symptoms take origin. At first such cases are puzzling as to why recovery does not take place, but sooner or later the psychic distress makes itself quite evident.

The above-mentioned types of defense reactions are only a few examples of this form of psychic abnormality. There are many other types, and one type may blend with another. In all forms of defense reaction in which there is an element of fear, anger or worry, the physiological reflexes evoked by these emotions may be present as an additional complicating factor.

As mentioned above, when we have concluded that a patient's complaints are entirely psychic, to make a diagnosis of neurosis is most inadequate. To complete our diagnosis we should determine, as nearly as possible, the nature of the psychic disturbance. In some cases this is easy, while in others it is difficult or even impossible. To ask such a patient if something is worrying him, or if he is in

trouble, is absolutely useless as he will always deny anything of the kind. To find out what is "eating on him" requires very subtle questioning, but usually when the patient begins to feel that we are really interested in him he gradually lets slip clues as to his psychic disturbance. Some patients tuck their emotions into their innermost selves and defy anyone to discover them. The majority, however, like to unburden themselves as soon as the ice is broken, but to break the ice is generally the difficult problem. We use diathermy in many cases as a real organic therapeutic measure, but in quite a number of cases there is also a psychic element and under the soothing influence of the treatment the patient tells the nurse many things that he would not tell his doctor, and unconsciously gives clues which help us to discover the underlying cause of his defense.

In my experience the great majority of defense-reaction patients simply need kind, sympathetic but positive advice. They need to be shown that their problems are not hopeless but can be remedied by certain efforts on their part. The most hopeless cases are those based on revenge, and I have never seen a recovery of this type of case until the revenge has been satisfied.

The chief reason for presenting this paper is to emphasize the fact that in a large majority of ill and injured persons two factors should be taken into consideration: first, the organic or somatic disturbance; and second, the complicating psychic element. I have found that the majority of physicians and surgeons center their study and treatment on the organic phase of the trouble, and when they have handled this organic condition satisfactorily and other symptoms appear, they brush them off with a diagnosis of neurosis. On the other hand, the neuropsychiatrist and psychoanalyst are so enthusiastically bubbling over with ideas regarding the psychic side of the patient that they give scant consideration to the organic element. What we need is a few more "mine run" physicians and surgeons who at least understand the elements of both the somatic and the psychic phases of disease.

Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

INDIANAPOLIS

October 3, 4 and 5, 1944

INDUSTRIAL MEDICINE IN ACTION

E. S. JONES, M.D.

HAMMOND

Industrial medicine as it is practiced today is comparatively new, showing vast improvement over methods used ten years ago. At that time only the larger industries and railroad companies required pre-employment medical examinations of their prospective workers, and only the railroad companies demanded periodical examinations of their employees. All of the industries at that time maintained the services of a physician to care for injuries sustained at their plants, but to consult the physician on matters of safety and hygiene was not thought of. This belongs to the new era of preventive measures in industrial medicine.

Industrial medicine has become one of the leading topics of the day in medical annals. One of the first published contributions, however, appeared in 1940, under the sponsorship of the Council on Industrial Health of the American Medical Association.

Being more familiar with industrial medicine and its relationship to the general practitioner in Lake County, I shall give you first the industrial code of ethics as set forth by the Lake County Medical Society, of the State of Indiana. The preparation of this code was begun in 1940, but it was not adopted until 1942.

RELATIONSHIP BETWEEN INDUSTRIAL AND PRIVATE PHYSICIANS

It is appreciated that no laws, rules, or regulations can be made that will apply equally to all. No rules can displace common sense and good judgment. In order that we may more nearly approach the Golden Rule in the relation between industry, labor, and the medical profession, the following principles are submitted:

1. *Pre-employment examinations.* It is recognized that the physical examination of applicants for work is the prerogative of an employer; that the time and place of such examinations are matters within his jurisdiction; and that he must have free choice of the physician who is to make the examinations. The foregoing assumes that the employer pays the entire cost of the medical service rendered. The examining physician in this circumstance is performing a service for the employer, and has primarily the single obligation to further the employer's interest. It is recommended, however, that in the broader interest of the community he accept the following rules of practice:

(a) Make available to the personal physician of an examinee a full report on the latter's examination; this to hold only in the event an examinee requests that a report be made.

(b) Willingly consult with the examinee's personal physician when differences in opinion exist regarding medical findings.

(c) Refrain from naming a practitioner to whom the examinee should report for correction of defects discovered in the examination.

2. *Occupational diseases and injuries.* The treatment of occupational injuries and diseases is the direct concern of an employer, and the facilities and physicians provided by him for that purpose must remain within his discretion. The employer is best served in these instances by physicians and surgeons who observe the general rules of the ethics of their profession. Specifically, the following points of conduct are considered important:

(a) It is not ethical for an industrial surgeon, while caring for an industrial injury or disease case, to urge the patient to have a concomitant and coincidental disease treated by himself at the worker's expense.

(b) Once a case of questionable liability to the employer is diagnosed as being of non-occupational origin, the patient is to be referred to his personal physician for further care.

(c) In general, a physician or surgeon is not to use his industrial affiliation as a direct means of gaining a private practice among plant workers. Emphasis is placed here on solicitation, low fee arrangements, and insinuation of reprisals against these workers who insist on care by physicians of their own choice.

Companion obligations rest with non-industrial physicians and surgeons in these matters:

(1) When a private physician suspects the diagnosis of an occupational disease or injury in a patient, he should, with his patient's permission, communicate the information to the proper plant doctor.

(2) When differences of opinion exist as to the compensability of medical and surgical conditions, the private physician, with the permission of his patient, is to confer with the plant doctor.

(3) Statements to workers that occupational diseases or injuries were not properly treated accomplish nothing constructive, and in any case the expression of such opinions is to be withheld until there has been consultation with the plant physician for the purpose of ascertaining all pertinent facts.

3. *Health supervisory programs.* Health supervisory programs may be properly carried on by an employer's medical personnel, if the purpose of the program be any or all of the following:

(a) To discover cases of occupational disease among employees exposed to known health hazards.

(b) To diagnose all possible illnesses which may influence adversely the earning capacity of workers or plant safety.

(c) To determine if workers returning from sickness absences have recovered sufficiently to carry on their jobs without injury to themselves or endangering the safety or others.

With respect to such programs the society considers certain ethical principles to be basic. They are:

(1) The results of clinical examinations must be made available to the personal physicians of the examined employee.

(2) No influence is to be brought to bear on employees in their selection of personal physicians for the correction of physical defects.

(3) No treatment for non-occupational diseases or injuries to be offered at the company's medical department, except in minor cases when enough treatment may be furnished a worker to make it possible for him to complete a turn of work with a minimum of injury and discomfort to himself.

(4) It is recognized that the plant physician is best qualified to judge a worker's ability to return to his particular job after an illness. In the interests of harmony in the medical community, however, when there is conflict of opinion in such cases between the worker's personal physician and the plant physician, the latter shall, at the request of the personal physician, consult with him on the case.

4. We recommend that all industries have doctors of their own choice, who are to act in the capacity of consultants, or as attendants, at plant medical departments.

We believe records of the physical status of all employees are valuable as protection to both the employer and employee.

5. It is against the policy of the medical profession to have any free medical examinations in any industry for whatever purpose, unless having been first submitted to and passed by the council of the local medical society.

We do believe in and encourage research work that may bring knowledge to the medical profession and benefit to mankind, but severely condemn the abuse of research for commercial purposes.

6. *Medical testimony before the State Industrial Board.* Any member of the Lake County Medical Society who has submitted expert medical testimony at a hearing before the State Industrial Board in a suit for compensation may petition the council to review all of the medical testimony submitted at that hearing. The petition must be made after a final decision in the case has been reached. The council will have discretionary power in the matter of deciding whether or not to review the case. Once the decision has been made to review the case, the council will make a reasonable effort to arrange a convenient time and place for the review. All of the physicians who submitted testimony at the hearing in question will be apprised of that time and place, and must be permitted to attend the review. The society has the duty to censure any of its members for apparently

flagrant deviations from the society's standards of competency and honesty, as revealed in such a review.

At that time it was thought a county society industrial clinic would be of some value. This materialized, was very successful, and proved to be our best-attended meeting. Cases which had been adjudicated were demonstrated, and methods of calculating disability were explained by Dr. P. H. Kreuscher, and a committee.

The benefits derived from our code have been the result of more careful regard to facts in court testimony. This applies to the plaintiff's as well as to the defendant's physician. It is my belief that a doctor's testimony should not be influenced one iota regardless of the side he is representing. The facts of the case should be presented regardless of the outcome, and the truth should never be compromised.

It is the industrial physician's duty to familiarize himself with the type of work being done by the particular industry; and to hold frequent conferences with the foremen, making them safety-minded. In an oil industry he should familiarize himself with the various types of possible dermatoses, and be prepared to prevent or treat them. In chemical plants he should devise means of prevention of skin irritations by prescribing protecting creams or neutralizing agents. Dust hazards should be checked and means of relief ordered. Lead and metallic workers should be protected by relieving dust hazards and educating them in the care of the hands. Also frequent blood tests should be taken. If stippling is found, a change of occupation should be recommended. Where a hazard is present from chemicals, a shower should be installed for immediate use. An antidote should be kept in a convenient place and those in charge taught how to use it properly. Cleaning fluids, such as carbon tetrachloride, et cetera, may be used only after consultation with the medical department.

Some of the hazards which can be eliminated in the interest of safety and also prevent lost-time accidents are as follows:

1. Gloves and loose clothing should never be worn around moving machinery.
2. Women employees should wear something to protect their hair around machinery.
3. Jewelry, such as rings, bracelets, or wrist-watches should never be worn around machinery.
4. Safety shoes.
5. Goggles.
6. Dust masks.
7. Dust hazards should be controlled by suction or exhaust fans of suitable means.
8. Competition with different departments helps to make all safety-minded.

The Committee of Industrial Health, of the Indiana State Medical Association, with the aid of Dr. Gatch, Dr. Spolyar and Mr. Hendricks, formulated a program for concentrated training for the

part-time physician, and a much longer and more extensive educational program for the full-time plant doctor. You have all been circularized from headquarters regarding this program.

The meeting at Indianapolis on February 25 and 26, 1943, was very successful. The comments received were most complimentary. Since that meeting I have received many communications containing comments regarding some valuable point which they have been able to put into practice.

The training machinery for the full-time plant doctor is all set, merely waiting for a customer. The demand for full-time medical directors is not great; however, should any plant contact us for a full-time physician, we are prepared to train the prospective doctor.

The greater the degree of co-operation between the management, the personnel department and the plant doctor, the greater will be the dividends in lost time, permanent and partial impairment to the workers, and the increase in production with the same manpower.

I believe that medical care is most expensive in industries where there is little or no cooperation between the medical department and the industrial officials. Shopping to obtain medical services for the least possible fees also is expensive in the long run. A doctor should be paid a fee which will encourage careful study and treatment of each case. An industrial patient should have identically the same quality of treatment as any private patient. Doctors are human, why should they spend as much time and give as much attention treating a case for which the compensation will be from one-half to one-tenth below the fee for a private patient? It just won't be done. As a result the cost to the plant is much greater.

It has been my experience in doing physical examinations for many years that a great number of applicants have been deprived of a livelihood because of some physical defect. These handicaps were not serious, such as hernia, large inguinal rings with an impulse on coughing, the loss of one eye or defective sight in one eye, artificial limbs, and disabilities from polio, et cetera.

The Workmen's Compensation Law in Indiana was such that industry could not afford to hire these men under such circumstances. A waiver for any physical defect automatically waived the entire law. If an accident occurred, the case would not come under the jurisdiction of the compensation law, but would have to be tried under the common law.

Appreciating the vast amount of hardships to these workmen, and also the fact that most of them could work with very little or no hazard to their fellow workmen and the industries, it was felt that some law should be written which would protect both the employee and the employer, and permit these workers to earn a livelihood. With these facts in mind, House Bill No. 11 was prepared and passed. This bill makes it lawful for an individual

to reject a part of the Workmen's Compensation Law and waive a physical handicap without nullifying the entire Act.

The procedure which must be followed in connection with this bill is as follows: Forms No. 50 are obtained from the State Industrial Board, on which the employee must list his handicaps and ask to waive any and all liability to the employer for injuries caused by accidents resulting from the handicap. One of these forms, with an affidavit from the doctor, must be sent to the State Industrial Board for its approval. If the board accepts the waiver, the applicant may be employed without jeopardizing the employer. This law, I believe, is the most humane piece of legislation which has been written for many years.

After the war many men may obtain work which otherwise would have been impossible. There are now approximately two and one-half million employable physically-handicapped men in the United States who should be at work helping the nation, and who could be at work if a waiver law were in effect all over the United States.

From time to time serious epidemics may develop which if precaution is taken early may prevent a vast amount of lost time in the industries; for example, the recent epidemic of keratoconjunctivitis which was present on both seaboards and also in several industrial plants in Wisconsin. As soon as information was received regarding this epidemic, your industrial committee formulated a notice describing the symptoms of acute keratoconjunctivitis and also outlined the management and treatment of this disease, should any cases be found in any of the industries in your territory. A notice also was sent to the industries, apprising them of this epidemic and the seriousness of it, asking their cooperation with the medical departments to immediately isolate any cases of keratoconjunctivitis as soon as they were found. As a result of this warning, there have been very few cases in our territory, and no semblance of an epidemic.

Another important question which has presented itself to industrial medicine is whether or not workmen may continue at their occupations while taking sulfonamides. This was investigated, and it was recommended that any individual who is sick enough to need sulfonamides is, indeed, too sick to remain at work. It was our advice that anyone taking sulfonamides should remain off work until he is entirely well.

SUMMARY

1. A code of ethics for industrial medicine has been adopted.
2. A yearly industrial clinic for the county society has been established.
3. A working program for postgraduate study in industrial medicine has been prepared.
4. A law has been passed, making it possible to employ the physically-handicapped.

A NEW TECHNIQUE IN DRAWING BLOOD FOR SERODIAGNOSTIC TESTS*

(Use of the Hemospast)

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LANSING, MICHIGAN

One of the remarkable developments in the nation-wide Venereal Disease Control Program has been the extent to which mass blood testing has been applied. Official records indicate that approximately 2,000,000 blood tests for syphilis were performed throughout the entire United States in 1936. In 1943, Michigan alone will record almost that many, or 1,800,000. Additional gains are expected in view of the more widespread acceptance of premarital and prenatal legislation requiring routine blood tests, together with the developing trend toward the inclusion of such tests as a part of the industrial employment procedure.

While the importance of industrial serology is generally accepted, the actual inclusion of the blood test in industrial medical examinations is by no means a universal practice. The Bureau of Industrial Hygiene of the Michigan Department of Health has attempted to bridge the gap between acceptance of the value of the blood test and its actual inclusion in the medical examination. In many industries we have found that routine blood tests are often omitted because it is considered an awkward and time-consuming procedure. This is true, and is particularly noticeable in those industries experiencing rapid personnel expansion, which has resulted in the overloading of medical facilities.

Blood tests are frequently omitted in industries employing part-time physicians whose time is limited and scheduled. These and other difficulties have been a decided handicap in our promotional efforts, and it is apparent that many of these difficulties can be overcome by improved methods of blood extraction. A new instrument, the hemospast, has been developed by John Soet, one of our engineers, to overcome the difficulties which we have encountered in promoting blood-testing programs for the detection of syphilis in industry and other large groups. (An engineer again makes a contribution to medical science.)

The problem was approached by a detailed study of the various techniques of blood extraction which have found limited or general use. These methods include the drip method, the Keidel tube method, the Luer syringe method, and the Cummings-Forsbeck method. The first and second techniques are not found in general use in Michigan for group

blood testing. The Cummings-Forsbeck (Selective Service Bleeding Kit) method is used almost exclusively by the Michigan Selective Service Examining Boards.

The objections to the drip method are too obvious for consideration. The Keidel tube, based on the evacuated container principle, has the advantage of speed and simplicity, but has not found general favor because of the expense involved in group testing and the difficulties encountered at the laboratory in removal of the blood clot from the container.

The Cummings-Forsbeck method depends upon the creation of a vacuum in the specimen vial by oral suction during the process of collection, and since it further requires a degree of manual dexterity to manipulate the evacuation system, the average operator has been slow in accepting this technique.

The most widely-accepted method of blood extraction in industry is by use of the Luer syringe with detachable needle. Its chief advantages are that the syringe is light, maneuverable, and simple to operate. The technique of this method has been observed in detail since we believe that the objections to blood testing are in reality objections to the syringe method of blood extraction.

The disadvantages of the syringe method as enumerated below are readily apparent when blood testing is effected on a large scale:

1. Excessive cost. It is necessary to have as many syringes and needles as patients, and at times as many as fifty to one hundred patients are examined daily. The initial cost of equipment plus breakage costs is considered excessive by some industries. The fact that barrels and plungers are not interchangeable adds to the breakage cost.

2. Sterilization and preparation of syringes and needles is a time-consuming and cumbersome procedure. Proper care requires immediate washing after use.

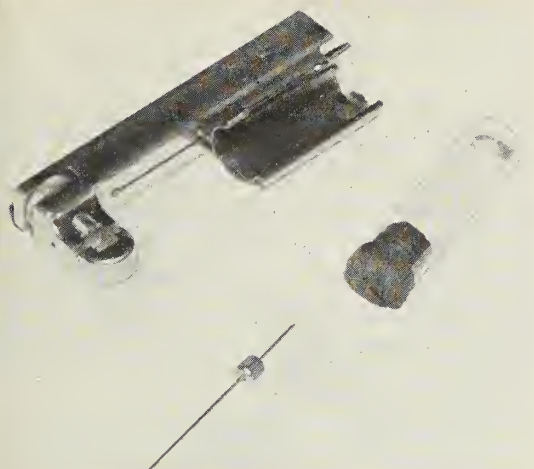
3. After extraction of blood from the vein, good practice requires the removal of the needle from the syringe before expelling the blood into the vial in order to guard against hemolysis. Observation revealed that blood vials are occasionally overturned during transfer of blood from the syringe to the vial. There is also a possibility of infection or contamination due to the transferring and handling necessary with this technique.

It is apparent that a definite need exists for a simple and practical blood-extracting technique,

* Presented before the Second Annual Industrial Health Conference of the Indiana State Medical Association, at Indianapolis, on April 20, 1944.

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FIGURE I

*Hemospast*

which will, if possible, retain the advantages of existing methods and eliminate their disadvantages. Such a method will no doubt prove attractive to the industrial physician and therefore stimulate the inclusion of blood tests in the medical examination program.

In view of the usefulness and efficiency of the evacuated container principle, it was decided to conduct the study along this line. The result has been the development of the hemospast, a device for holding a standard 10 cc. rubber-stoppered vial and a standard double-pointed blood-letting needle. (Fig. I.) The stopper is composed of self-sealing rubber so that a vacuum can be induced in the vial and maintained for an extended period of time.

The simplest means of creating a vacuum is by the use of an ordinary water aspirator pump, which can be attached to any sink faucet. A syringe needle is attached to the hose of the aspirator pump. The aspirating needle is inserted through the rubber stopper for a fraction of a second and then withdrawn. A vacuum of twenty to thirty inches is created in the vial, which provides ample negative pressure to fill the vial with blood after venipuncture. The average time for evacuating fifty vials is about four minutes. These vials so evacuated will retain sufficient vacuum for several weeks, and therefore this process need not be repeated each time a blood specimen is desired.

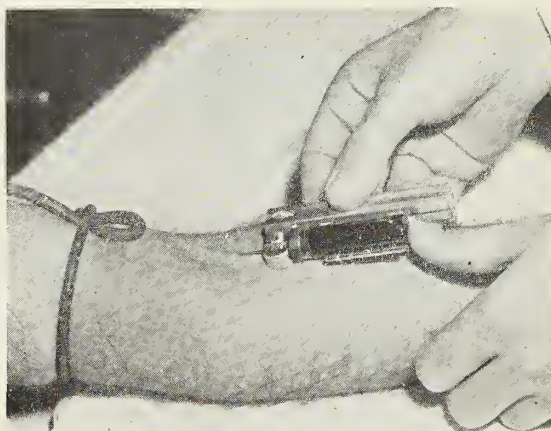
The technique of operating the hemospast requires no special skill, and proficiency in its use is acquired after a few blood extractions.

The double-pointed blood-letting needle is inserted into the slot provided for it on the instrument and is fixed by a locking mechanism which allows proper alignment of the bevel of the needle. An evacuated vial is then placed into a sliding clamp which allows movement toward the fixed

needle. After preparation of the patient's arm, the needle is introduced beneath the skin, but not far enough to puncture the vein. The vial is then pushed forward, allowing the back end of the needle to penetrate the stopper. This does not disturb the vacuum in the vial as the front bevel of the needle lies beneath the skin. The hemospast is now pushed slightly forward, allowing the needle to enter the vein. Entry into the vein is immediately detected by the flow of blood into the vial. (Fig. II.) When the vial is filled, the needle is withdrawn from the vein. Upon removal from the instrument the vial is automatically sealed and is ready for labeling and mailing. The needle is removed from the instrument and placed in a disinfecting and cleaning solution. Another sterile vial and needle are inserted for the next extraction.

The instrument and technique described has been used on more than seven thousand patients during the past year in one of the large venereal-disease clinics and in some of the plant medical departments in Michigan. Physicians and technicians who have used this method commend its speed,

FIGURE II

*Hemospast technique of blood extraction*

convenience, and simplicity. The reaction of patients has also been favorable.

We believe that there are several advantages to this method, which may be summarized as follows:

1. It combines simplicity of operation with speed and efficiency. The actual time required to take a blood specimen is materially shortened.
2. It eliminates the expense involved in purchasing a large number of syringes and replacing those broken by handling. Needles and rubber caps lend themselves readily for re-use. The life of the glass vial depends upon the care in handling.
3. It eliminates time-consuming procedures involved in washing, drying, and sterilizing syringes. Preparation of the needle and vial may be done well in advance of their use, and there is no necessity for washing and sterilizing

needles during the actual examination procedure.

4. It eliminates the necessity for an additional assistant in some clinics.

5. It eliminates the transfer of blood from a syringe to blood vial, and therefore prevents accidental spilling and overturning of specimens. Blood hemolysis occurs less frequently by avoiding transfer of blood from syringe to vial.

6. Actual clinic experience has shown that the unpleasant psychological effect on the patient is diminished.

It is hoped that the hemospast technique of blood extraction will prove a worthy contribution to venereal-disease control programs, and that it will be of material assistance to all those interested in the promotion of syphilis-control programs.

PRIMARY CLOSURE OF PILONIDAL CYSTS AND SINUSES

MAJOR M. CORNACCHIONE, M.C.

BAER FIELD

FORT WAYNE

There are certain aspects of surgery in the military service which are different from those in civilian life. Pilonidal cysts and sinuses are more apt to become symptomatic in the military service than in civilian life because of duties peculiar to the service.

True pilonidal cysts and sinuses may be single but are usually multiple. Many pilonidal cysts are marked on the skin by crusted papules. Sinuses characteristically open in the median line over the lower sacrum or coccyx, and when probed are found to be directed upward into a cystic dilatation. The sinuses may be lined with epithelium which contain hair follicles and sweat glands extending to a depth of several millimeters or centimeters. One or more sinuses may open on either side of the median line, and these are accessory sinuses resulting from secondary infection of the true sinus and cyst. A tuft of hair may protrude from the sinus orifice, and if so, it is diagnostic.

In this series of cases an abundant amount of hair was present in 80 per cent of the cysts. Cyst structures were located from within the skin to the fascia of the sacrum and coccyx except in one case where the tract extended below and beneath the coccyx and necessitated removal of the coccyx. All degrees of infection were found, varying from an acute cellulitis and abscess formation to chronic low-grade infection. The majority of patients in this series presented multiple sinus openings, and in some cases the tracts had been replaced by granulation tissue. All patients complained of a discharge, either constant or intermittent, from the sacrococcygeal region. In most instances a tumor mass also was noted. Some patients had no pain, but in others the degree of pain varied, depending on the acuteness of the infection. The pain was less when drainage was adequate. If the cyst was acutely inflamed, an incision was made to establish drainage only. These patients were instructed to return in several weeks for examination, and

when the infection had subsided the radical procedure was done.

This series of cases was treated only by radical excision of the sinus openings, sinus tracts, cysts, and with minimum loss of surrounding normal tissue and skin.

At the time of operation the skin was surgically prepared and a local block infiltration anesthesia was accomplished. Aqueous methylene blue solution was injected slowly to allow complete coloring of cysts and tracts. A vertical elliptical incision was made, and by means of sharp dissection was carried down to the sacrococcygeal fascia, thereby removing the entire sinus and tracts en masse. In some instances a transverse elliptical incision was made when the sinus opening was markedly laterally placed. A cure cannot be accomplished if any portion of the tracts or cysts are left in situ. Careful search was made for any tracts which extended up, down, or laterally, and if found, sharp dissection of the tissue was carried out. Hemostasis was always carefully completed.

There is much discussion as to whether the wound should be closed by primary suture or left open and packed. Several reasons are advanced against primary closure of pilonidal cysts and sinuses after radical excision, some of which are that the tissue is infected; that the operative site is in close proximity to the anus; and the probability of dead space and resulting tension from primary closure. This series of cases had complete primary closure in spite of the fact that the excised tissue showed evidence of chronic infection, proximity of the anus, and the probability of dead space and resulting tension. Some of the dead space can be eliminated by lateral, deep through-and-through-closure suture and with a very thick pyramidal dressing and wide adhesive tape firmly applied, giving mild compression. The skin was accurately approximated with minimum tension and with the use of nylon suture or other fine nonabsorbable suture material. In addition, before surgery was started, all cases had a rectal and perineal preparation which consisted

TABLE I

Patient No.	Age	Duration of Subjective Symptoms	Previous Procedures	Type of Treatment	Postoperative Hospital Days	Approximate Postoperative Follow Up
1	22	4 years	None	Total excision and primary closure	10	12 months
2	29	3 years	None	" " " " "	13	12 months
3	24	2 weeks	None	" " " " "	10	10 months
4	23	1½ years	Incision and Drainage 1½ years previously	" " " " "	12	10 months
5	22	6 years	Repeated incision for drainage of abscess	" " " " "	9	9½ months
6	24	2/12 year	None	" " " " "	10	5 months
7	24	2/12 year	Incision for drainage of acute abscess (January 7, 1943)	" " " " "	14	4½ months
8	23	1½ years	Incision for drainage about 1½ years previously	" " " " "	13	2½ months
9	20	3/12 year	None	" " " " "	9	2 months
10	27	2 years	Incision and drainage—May, 1942	" " " " "	13	6 months
11	21	3 years	None	" " " " "	14	5 months
12	24	1 year	None	" " " " "	15	5 months
13	23	3 years	None	" " " " "	16	5 months
14	27	6 months	None	" " " " "	14	5 months
15	21	6 months	None	" " " " "	12	4 months
16	22	8 months	Radical excision June, 1943	" " " " "	12	3 months
17	30	3 months	None	" " " " "	12	3 months
18	20	2 months	Incision and Drainage—July, 1943	" " " " "	12	3 months
19	19	4 months	None	" " " " "	14	4 months
20	24	3 months	None	" " " " "	12	4 months
21	23	6 months	None	" " " " "	12	3 months
22	24	5 months	None	" " " " "	13	3 months
23	27	9 months	Radical excision—May, 1943	" " " " "	13	3 months
24	23	5 months	None	" " " " "	15	3 months
25	31	7 months	None	" " " " "	13	3 months

Total postoperative hospital days for the series was 312.
Average postoperative hospital days per patient was 12.48.

of cleansing the anal area with soap and water, followed by bichloride of mercury solution. Then a protective dressing and packing was placed about the anus before the operative procedure was started. An enema was given on the morning of operation. There was no concern as to bowel movement until the third or fourth postoperative day, by which time the wound was sealed. Only two cases had any postoperative drainage, and this was due to mild superficial infection and lasted only a few days. Healing occurred rapidly and with minimum scarring. The hospital stay in these two cases was extended to fifteen and sixteen postoperative hospital days. Keeping the wound dry and clean is extremely important. The dressings were not disturbed for seven to eight days unless evidence of infection appeared or soiling necessitated changing of the dressing.

SUMMARY AND CONCLUSION

1. In this series of twenty-five cases the soldiers were returned to full military duty in an average of

12.48 days following radical excision of pilonidal cysts and sinuses with primary closure.

2. In all instances there was primary healing, except in two cases which drained for about three days but still proceeded to heal without delay, secondary suture or granulation.

3. Many of these patients were transferred for military reasons so that prolonged follow-up was impossible. However, from the follow-up that was possible, it is felt that the results justified primary closure because of the short period of hospitalization.

4. We think that proper perineal preparation, radical surgery, sincere attempt at elimination of dead space and primary layer closure and compression dressings that are not disturbed for seven days is the method of choice in the treatment of symptomatic pilonidal cysts and sinuses, with minimum loss of time, in the military service.

5. In our experience primary closure after radical excision of pilonidal cysts and sinuses has been attended by the most satisfactory results.

EYE TRAUMA IN AMPHIBIOUS TROOP OPERATIONS OF THE U.S.S. SOLACE

LIEUTENANT COMMANDER ALBERT F. CLEMENTS, (M.C.) U.S.N.R.

FLEET POST OFFICE, SAN FRANCISCO, CALIFORNIA

Anatomically, the eye is considered to be fairly well protected. It may be of interest to know what proportion of men wounded in some Pacific landing actions have suffered eye trauma.

In the group under study aboard this United States Navy hospital ship, 984 patients were seen with various battle injuries, and of this number 48 received ocular trauma.

Considering the type of resistance encountered, mortar shells, hand grenades and rifle bullets, the percentage of eye injuries is fortunately low, especially in view of the fact that of this group 120 patients had wounds of the face. Of the 48 patients with eye injuries some had extra-ocular foreign bodies in one eye and intra-ocular or penetrating ones in the other. Only four patients were seen with bilateral penetrating intra-ocular trauma sufficient to cause permanent total blindness. In this group of eye injuries 23 were non-penetrating and 33 penetrated the eyeball. The fighting man on the beach and farther in from the shore must see at what he is shooting and also from where he is being attacked. This obviously must expose the eyes.

Eye injuries, however minor, result in immediate blurred and painful vision. The necessary

courage for such landing operations can hardly be expected when the man can not enjoy his accustomed visual acuity, making all eye trauma serious.

The foreign bodies seen were brass, coral, cast iron or lead, some non-magnetic, presenting a difficult problem in their removal. However, when small foreign bodies of metal were removed from the cornea or sclera the usual prompt healing expected from industrial experience was also obtained aboard this ship. Coral foreign bodies are not given to easy removal from the cornea or sclera. Their dislodgment requires a great deal of added trauma, and healing of the eye surface is much slower, although out of all proportion to the extra-trauma obtained in dislodgment. Delays of twenty-four to forty-eight hours which so well facilitate the removal of metal, cinders, or sand fail to give sufficient appeasement to the task at hand. The coral is apparently fairly well tolerated by the cornea, although subjectively equally as painful as any other foreign body on the eye surface.

Since the average stay of the patients on this hospital ship was only seven days, the final healing results can not be reported. No doubt vision improved in most eyes under more prolonged care in land-based hospitals.

ABSTRACT

NEW VACCINE FOR POLIOMYELITIS REPORTED BY THREE CHICAGOANS

A new vaccine for infantile paralysis is reported in *The Journal of the American Medical Association* for July 8, and results obtained in mice seem to offer encouragement as to its usefulness. The poliomyelitis virus is inactivated with a new technic of ultraviolet irradiation developed by a group of Chicago investigators.

Albert Milzer, Ph.D.; Franz Oppenheimer, Ph.D., and Sidney O. Levinson, M.D., Chicago, report that "Mice immunized with three doses of the irradiated poliomyelitis vaccine developed significant resistance to intracerebral inoculation and also specific serum neutralizing antibodies. The irradiated poliomyelitis vaccine exhibited no significant loss of potency after four and a half months storage at 3 C."

The new technic was first announced in *The Journal of June 24*. By it bacteria and viruses are completely killed or inactivated in less than one second by exposing them on continuously flowing thin films to ultraviolet rays from a newly-developed lamp.

"The present paper," the three investigators say, "is a preliminary report on the preparation and antigenic

studies of a completely inactivated vaccine prepared from the mouse adapted Lansing strain of poliomyelitis virus which not only evokes the formation of specific neutralizing antibodies in immunized mice but also confers a high degree of protection against subsequent intracerebral inoculation. . . ."

"Although there are a few publications of the effectiveness of ultraviolet irradiation in destroying the poliomyelitis virus, to our knowledge no one has made antigenicity studies of irradiated poliomyelitis vaccines. It has been shown repeatedly that monkeys vaccinated with various completely inactivated poliomyelitis virus preparations develop little or no immunity, while active virus vaccines may stimulate immunity but are too dangerous for human use. . . ."

Swiss mice were used by the three men. They say that "The presence of neutralizing antibodies against the Lansing strain . . . in undiluted pooled serums obtained from selected vaccinated mice was demonstrated as early as one week after a single dose of vaccine. One week after the second and third doses of vaccine the antibody titer had increased at least tenfold. . . ."

THE JOURNAL OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

Copyright, 1944, Indiana State Medical Association

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Indianapolis 4, Indiana

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AUGUST, 1944

Editorials

"EDUCATIONAL DEFICIENCY"

"Educational Deficiency" is the title given to the rejection of 240,000 selectees by the induction boards of the country, and it is a friendly title; by that we mean that it covers a more serious term. "Illiteracy" might well have been used, for that is just what it means.

For some time the nation has been very much concerned about the rejection of an enormous number of selectees because of physical disabilities. There was a great hue and cry when the first figures were given out in this regard, and the proponents of socialized medicine found much satisfaction in these findings. They hopped right on to the suggestion that if medicine were regimented the health of American youth would be conserved.

Now we are told that we have thousands of young Americans who are illiterate. Figures taken from the *Selective Service Bulletin* show that there are more rejections for illiteracy than there were casualties in all the battle fields in which American troops have fought, as of May twenty-fifth.

The bulletin states, "Failure to pass Army intelligence tests, primarily because of educational deficiency, has deprived our armed forces of more physically-fit men than have the operations of the enemy."

Two hundred forty thousand is a lot of men to

have been rejected for military service, particularly when the rejection comes not as a result of physical disability. As the bulletin states, "These data emphasize the importance to the nation as a whole of insuring that every American citizen has the opportunity for a reasonable minimum of education." This 240,000 would have provided the equivalent of fifteen divisions of fighting men. This number, added to the thousands who have been rejected for physical reasons, amounts to a large army in itself.

We of Indiana will have a hard time reconciling ourselves to this degree of lack of education; for decades we have boasted of our state educational system and, while it is true that among the older folk we occasionally find one who has had little or no "school larnin'," most everyone has had a few years of school, be it of the city variety or the one-room, one-teacher building that once dotted the rural landscape throughout the state.

Now the consolidated schools have taken over in most state areas; the school bus stops at the very door, at least at the nearest cross road, to pick up the youngsters, returning them to their homes each evening. Our teaching staffs have developed until they have reached the top; we have athletic facilities in all these schools, which is, of course, an added inducement.

There are sections of the country, however, that do not have all these advantages; there are communities that do not enforce an attendance at school, resulting in a large number of young folk growing up without even the rudiments of an education. There would seem to be a lot of work ahead for the educational interests, a work in which we should all take part. Young America is entitled to an education—Young America must have that education!

BIRTHRIGHT vs. A MESS OF POTTAGE

Some years ago we reported in the editorial columns the result of an interview with the manager of the Indianapolis branch of a chain-store optical company, a company that from time to time operated under several different names. It was pointed out that due to the Indiana optometry law this company could not employ *hired* optometrists to carry on its business, so it resorted to a clever expedient to get around this phase of the law.

They sent out post cards over the state, stating that the recipient would be paid something like forty dollars per week for working in these branch stores—in many instances the additional bait of a bonus was dangled before the eyes of such gullibles as answered the card. We acquired a dozen or so of these post cards, from all over the state, and became more than casually interested in noting

that the addressees were in each instance sixty or more years of age.

This was more than a coincidence; the company dared not hire optometrists, so it wanted licensed physicians — and it cleverly was figured out that it was more than likely that there might be several licensed physicians in Indiana who were not doing so well, financially, and to whom a forty-dollar-a-week bait might be enticing. It was, as after-results showed. At one time we personally checked several of these stores, in every instance finding therein, posing as the "eye doctor," a rather elderly man and one whose practice had dropped to an alarming low.

We talked with several of these physicians, both at the time when they were so employed and afterward, and they all have told the same story — that they knew nothing about fitting glasses when they took over the job, and knew little or nothing about it later on.

As stated in our editorial remarks on the subject following our Indianapolis call, we were told by the manager who sought to engage our services, "It is not necessary that you have refracting experience; we will have our Chicago expert come down and teach you in a half day all we want you to know."

This thing is still going on right here in Indiana, in several of our larger communities. We have men with legitimate licenses, many of whom formerly were members of their local medical societies, who now are debasing themselves and disgracing the noblest of the profession by *selling themselves*. They are fraudulently posing as trained "eye men," which they are not.

They, of course, are not amenable to discipline by the local medical society, since they no longer are members, but we are wondering — Are they not aiding and abetting a violation of the optometry law? On several occasions the Indiana State Board of Medical Registration and Examination has revoked licenses of those aiding and abetting a violation of the medical law, and in every instance this revocation has been upheld by the courts. Physicians who sell their most valued possession — their professional standing, as is being done by these men who operate in these optical stores, deserve nothing less than a forfeiture of their license to practice the greatest and the noblest of the professions.

A new drive to get additional physicians into this work is now on. A card which reads as follows has recently been received by numerous physicians throughout the state:

"I would like to enter into an arrangement with you, requiring your full-time service away from your office. If you are willing to leave town, can offer you an attractive opportunity with a permanent arrangement. This is permanent in Indiana with a definite weekly guarantee. If you are

interested and available for any part of your state, wire me (COLLECT) or write special delivery at once and I will contact you and make further arrangements. Please give me your telephone number so that I can call you. Thanking you for an immediate reply, I am . . ."

MORE ABOUT BRUCELLOSIS

In the July number of *THE JOURNAL* appeared an article concerning the recent typhoid fever epidemic that occurred in northeastern Indiana. A report of nine cases is presented by Dr. Virgil C. Miller, of Akron, in which the clinical symptoms are carefully pointed out, together with some notes on the treatment of these cases.

Reference is also made to one case which responded to the agglutination test for brucellosis, and the writer carefully points out the symptoms which differed materially from those in the other eight cases. He reports that this patient was extremely ill, and that he required hospitalization.

The writer further states, "I have reason to suspect that he had during the past year undergone the acute phase of brucellosis, which he had mistaken as 'flu,' and as a result of his weakened condition his reaction to typhoid was extremely severe."

Here we have an almost perfect clinical picture of a chronic brucellosis, a condition too often overlooked. It also is pointed out that this patient's dairy herd was later checked, and it was found that more than half of the cows were positives.

Several lessons may be learned from this brucellosis incident, chief of which is the fact that the disease all too often is not recognized. In this instance it took a typhoid epidemic to bring out the diagnosis.

Another feature which we already have pointed out in articles concerning this disease is that the medical men in the smaller communities are usually the ones who locate cases of brucellosis. It is true that the disease is more likely to spring up in the rural communities, but it is an established fact that our urban centers are by no means free from this infection.

We believe that the medical profession as a whole is slow to accept the facts about brucellosis; hence, are again calling your attention to this disease — be on the alert!

GOOD-BY, OLD-TIMERS!

The American Pharmaceutical Association announces a complete revision of *The National Formulary*; new edition expected to be ready late in 1945.

Marked changes in the context will be noted, since it is stated that nearly one-third of the drugs mentioned in the older editions will be deleted, and that some one hundred fifteen new names will be

added. One radical change will be the substitution of English names for those formerly appearing in the Latin language. The latter, however, will in many cases follow the English term, as a secondary title. Metric dosage will be emphasized, although the present apothecary dosage will be maintained, it being felt that many physicians were not ready to drop the use of the old dosage formulae. (This might be considered as a friendly gesture to the oldsters.)

It is planned to standardize the enteric coated medications, since the claim often has been made that many of these preparations are mis-named. Also, it is said that the new Formulary will be more "self-contained," making it unnecessary to look up many items in the Pharmacopoeia.

The various state pharmaceutical associations are being asked to go over the proposed list of deletions and suggest their own ideas about them.

Looking over this list we find many old-time friends, several of which we have been wont to include in our armamentarium. A number of these drugs would be classed as "strangers" by the more recent graduates in medicine, since they are not even mentioned in most modern courses of therapeutics. However, to the oldster they have been stand-bys for years, and they will miss them if they have occasion to consult the new edition of the Formulary.

For several years past the Council on Pharmacy and Chemistry of the American Medical Association has issued a volume entitled "Useful Drugs." With each succeeding volume more and more drugs are dropped from the list. Now comes the Pharmacist's Bible, with approximately one-third of the formerly-mentioned drugs dropped from the list.

Among the old-timers found in the medicine kit or dispensing room of the older members of the profession, but are now termed passé, might be mentioned Blue Flag; Bryonia; Calendula; Chionanthus; Echinacea—there will be a lot of mourning over the passing of this one—Elix. Buchu and Potass. Acetate; Elix. Pepsin and Bismuth; Phytolacca; Plaster of Cantharides; Pulsatilla; Tr. Capsicum and Myrrh; Tr. Cimicifuga and Tr. Sanguinaria. There are also many others dear to the heart of the old-time doctor, many of which he swore by and declared that he could not practice without.

All of this means that chemotherapy is coming into its own; or does it mean that we have a chemotherapy wave—one that will ride the crest for some years and then give way to something new? We doubt it, since chemotherapy offers so much and the field is yet almost virgin.

As one of those who have been in practice for more than four decades, however, we pause to pay tribute to a list of drugs that we, at least, thought would be with us at all times. Compelling us to become modern is a jolt, but we can take it!

WHAT DO DOCTORS READ?

The title of an interesting "President's Page" in the May number of *Medical Annals of the District of Columbia* is "What Do Doctors Read?" In this article Dr. Fred R. Sanderson begins with the premise that local physicians were never busier than now, yet many of them find time to maintain the greater part of their reading routine. He also takes cognizance of the fact that most of the men now in practice in that community are no longer young, and it is a fact that it is the older medical group who are bookworms.

He states that only recently he heard a physician inquire as to the Wagner-Murray-Dingell Bill, wanting to know about its chances for passage. This man, so it was learned, knew very little about the proposed law; he just had heard that there was such a thing, and when material concerning the bill was mailed to him it promptly went into the waste basket. Doctor Sanderson says such reports are rather typical.

He concludes his observations with the statement that problems with which we presently are faced must not wait too long for a solution, that these are problems of today, and that they must be met *today*. His final statement will bear repeating: "An informed medical profession will be a strong profession."

We are inclined to believe that Doctor Sanderson is correct in his assumption that regular readers among the profession still continue that hobby. Employees in the bookstores which we patronize tell us that their "doctor customers" continue to buy books; many of them buy more books than in former years. Historical and biographical books are preferred; little fiction is sold to the older physicians.

We personally know of many physicians whose interest in medical literature continues unabated. They keep up on the latest books in the medical field, the while looking over several medical journals.

Further, it is our opinion that the younger group is slipping in this regard; "too busy" is their excuse—a poor excuse it is. We often recall the remark an elderly physician made to a younger colleague: "Keep a medical book or magazine handy in the downstairs hall while waiting for the better half to get ready to go some place; you will be surprised at how much medical information you will gather."

Personally, we have found it to be a good habit to patronize a good bookstore and there make the acquaintance of a salesperson who knows what it is all about. We have in mind a young lady from whom we have been buying books for a good many years. When we enter that department she either has or has not something that is sure to be at least worth looking over. It was through her that we were fortunate enough to 'get in on' the Harvey Cushing "Biography of Andreas Vesalius," a

very fine edition limited to some eight hundred copies. She did not have it in stock nor was it being listed in the catalogues, but by perseverance she finally located a copy which we now prize very highly. Morris Fishbein says of this book, "It will be invaluable within fifty years."

Following the present war there will be many new, authoritative medical books; traumatic surgery texts, for instance, will have to be rewritten, while those pertaining to tropical medicine will be practically new to the profession of this country.

Thus, it behooves us to "keep in tune" on our reading, for reading is more or less of a habit—once dropped, it is hard to resume. Medicine will progress more within the next few decades than at any other time in history, and it is up to every one of us to keep in step. *Keep up that reading habit!*

Editorial Notes

Sometime ago we made editorial comment on the exposure of a "kickback" racket, in Brooklyn, involving several local physicians engaged in industrial work, who were charged with accepting split fees from roentgenologists to whom cases were referred. *The New York Times* cites further facts about this evil, stating that 272 Brooklyn physicians were penalized by the Industrial Commissioner of the State Department of Labor. Nine of these physicians lost their licenses to engage in compensation case work, while 263 were given a license suspension. Seventy-two others were reprimanded. Similar action was to be taken, so the Commissioner reported, against several hundred other physicians in the New York City area. From the newspaper report it would seem that this split-fee evil had reached "magnificent" heights in that area.

Ivor Griffith, president of the American Pharmaceutical Association, in a recent address before a meeting of the National Physicians Committee, in New York City, said, among other things:

"No charitably-minded citizen can overlook the fact that there are many provisions in the Wagner-Murray-Dingell Bill which incline toward a new order. But the naiveté and novelty of the Bill, the cadginess and the codlingness of it, the 'I am my brother's keeper' gospel of it, are so acceptable, not just to the lame and the halt but to the tame and the dolt, that opposition to any portion of it and on any score is doubly difficult. Therefore, such opposition must be doubly impelling, incisive, intelligent, and invincible. As such, it must reach legislators and representatives by way of the people who elect them, a people who will have to be convinced by sound arguments that this 'cradle to the grave' program is not compatible with our idea of American liberty."

"Vitaplus" just didn't "plus," according to reports from several quarters. This high-sounding name was given to a product that was claimed to increase gasoline mileage from 20 per cent to 39 per cent. The Better Business Bureaus in several areas made tests of the products, as did officials of several cities—all tests showing these claims to be fraudulent. Court action was had in many instances and the chapter seems to have closed when the manufacturing company went into bankruptcy.

Although limited as to number of pages, *Outdoor Indiana* continues to be one of the most interesting magazines that come to our desk. It is published by the Department of Conservation, under the capable editorship of Arthur P. Tiernan. In the May number is a merited tribute to Colonel Richard Lieber, the "father of Indiana's state parks," a full page being devoted to the work of this man, who recently died. It is a strange coincidence that Colonel Lieber was suddenly stricken while on a visit to McCormick's Creek, the first of the state parks to be created while he was at the head of the department. This number also renders homage to the memory of Mrs. Julia Strauss, whose indefatigable efforts, over a long period of years, saved Sugar Creek for future Hoosier generations. Sugar Creek, as you probably know, is that area in which are located "The Shades" and "Turkey Run."

It is about time to re-tell one of the best legislative tales that we have ever heard, one that points out the moral: never be too cocksure about a candidate that is placed on the ticket to satisfy some bloc or other. A man was nominated as one of the representatives from Lake County, chiefly because he was a "power" in a certain rather large group. In the early days of his freshman year in the legislature, however, it developed that he had some quaint ideas about things. Along came a proposed law which the medical profession opposed most heartily; calls were sent out to the various local legislative committees, asking them to contact this or that lawmaker. We were asked to go down to Indianapolis and see our local chap, taking with us another member of the local society. We located the solon and, knowing his habits, invited him to one of the bars in the Claypool—they had two of them in those days. After the preliminaries we broached the subject we had in mind, presenting our most cogent arguments, but we felt we were making no headway. Finally, we asked him, point blank, if he would give us any consideration. His reply was a classic, but made it clear that he still was "agin" us. Here it is: "That would destroy the constitutionality of the individual rights of the people as a public!" With that unanswerable argument put straight to us, the Legislative Committee of the Lake County Medical Society gave up the ghost, taking the midnight train for the Sand Dune Region.

President's Page

In 1936, Dr. James B. Maple published a medical history of Sullivan County. This is an interesting and well-written book, completely covering the first infiltration of pioneers into the forests north of Vincennes, where they settled the villages of Carlisle and Merom, down to the year 1936. This history deals only with men who have lived in Sullivan County, but it deserves to be read by doctors in every Indiana county, for the conditions described are common to the whole state.

It is a history of medicine in the rural and backwoods country, away from the cities and centers of progress. New discoveries were slow to penetrate this area and the products of science and research were not available. The outstanding fact portrayed in the book is that progress in medicine has kept pace very closely with the social and economic growth of the state. The beginning of the present century marks a turning point. The coming of the telephone, electricity, the automobile and good roads brought a new era in the practice of medicine. The inventions and discoveries that have carried civilization farther in the last forty years than it had moved in all of the preceding centuries also brought a new and undreamed-of acceleration to the science and art of medicine.

Prior to 1904 surgery was practically unknown in Indiana, outside of a few of the larger cities. A few operations were done in the home by surgeons brought out from the populous centers, but the majority of cases were allowed to take their own course toward recovery or death. Such present-day emergencies as appendicitis, obstruction of the bowel, strangulated hernia, gall stones, ectopic pregnancy and many others were treated only with medicines. The chances for recovery for these patients were decidedly remote. The following account of a surgical operation printed in an old Sullivan County newspaper is included in Doctor Maple's book. It is interesting because it happened within fifteen miles of the city of Terre Haute, and happened only sixty-four years ago.

"On Thursday, March 11, 1880, Dr. W. W. Purcell of Reelsville, Indiana, with Dr. Hiatt of Centerville, and Drs. Plew and Thralls of Pittsburg, performed the operation of ovariectomy upon Mrs. George Johnson, near Farmersburg, this county, removing a tumor weighing thirty pounds. Mrs. Johnson has borne herself bravely under the circumstances, and promises to make a good recovery. The disease was taken to be abdominal dropsy for several years, and a few weeks ago Dr. Hiatt saw the case and pronounced it ovarian tumor. Dr. Purcell, being widely known to be an expert in such diseases, was called to the case and performed the operation as stated."

This story closely parallels that of Dr. Ephraim McDowell's celebrated first ovariectomy, which he did in his home in Danville, Kentucky, in 1809, the patient being Mrs. Jane Todd Crawford. Seventy-one years had elapsed since McDowell's operation, but there was no apparent progress in the practice of medicine and surgery. There was the same inability of the family doctor to diagnose the condition, the operating room was the same—the family kitchen—and there was the same lack of asepsis. The only advance was that chloroform had been discovered to be an anesthetic.

Strangely enough, both of the patients lived to a ripe old age, and both now lie buried a few miles apart in Sullivan County.

While surgery for the rural population was thus backward, the practice of medicine was no more advanced. The remedies offered were the same old empirical drugs that had been in use for a hundred years. There was little scientific basis for the use of any medicines prescribed. The diagnostic ability of the average country doctor was lamentably poor.

It is a satisfaction to know that during the past four decades medicine has kept in step with all of the miracles of scientific discovery. The frontiers have been pushed back, and there is no longer any backwoods in Indiana.

Josephant

LAY DOMINATION OF MEDICAL PRACTICE*

W. D. GATCH, M.D.

Dean, Indiana University School of Medicine

INDIANAPOLIS

My contention is that lay domination is the cause of the greater part of the evils which afflict medical practice. We can no longer ignore these evils. They are dangerous to our professional unity and professional privileges. We are accused of not giving the people proper medical care and of selfish opposition to necessary changes in medical practice. We are threatened with state regulation. What has brought these troubles upon us?

Forty years ago the amount of money which the people paid for medical care was not large. They paid more to patent medicine companies than to their doctors. Little laboratory work was done. People were sent to hospitals only in case of serious illnesses. They were born at home, stayed at home when sick, and died at home. Hospital and health insurance were unknown. Specialists were few, and nearly all of them did general practice. Nearly all medical care was still given by the general practitioner. Medical colleges were conducted entirely by doctors. No effort had been made to enlighten the people on every fact of medical science. In short, the field of medical care was not exploited by laymen other than the vendors of patent medicines.

Now all this has changed.

Medical science has made spectacular advances which have fascinated the people.

Medical education has tried to keep abreast of medical science. The medical student, before the war, had to study at least eight years before he could enter general practice, and at least twelve years before he could enter a specialty. The medical curriculum has been overloaded till it now contains more than any medical student can master. Lay influence on medical education is now great.

The people, at great expense and by every possible means of instruction, have been told, chiefly under guidance by lay agencies, all that anybody knows and in most instances a great deal more, about all the mysteries of the human body and the ills which may afflict it.

There has been a great construction of hospitals. The investment of money in them is tremendous. Their maintenance is a major industry. It is no longer customary to be born, to be sick, or to die at home. These great events of life now take place in a hospital.

Great numbers of people now carry sickness insurance. Insurance companies are now a great power in medicine.

Public health departments are now great and opulent.

An army of social and welfare workers has moved in between us and the sick poor. This is already claiming recognition as a distinct profession.

Industrial plants have established medical departments to care for their workers and, in many cases, for the families of the workers.

The world is in the midst of a great social revolution caused by the rapid progress of technology. Medicine is suffering the pangs of social change.

The war has disrupted civil practice by taking from it nearly all physicians under fifty years of age.

The foregoing facts prove, among other things, that we no longer have undisputed control of medical care; that multitudes of laymen now make a living out of it, in one way or another, and threaten to subjugate us; that we are in an ugly situation which many doctors think is hopeless. It is not! We still have a good fighting chance to save ourselves. It may still be possible to convince the people that we are worthy of the privileges they have granted us, and that lay domination of medical practice is not for their good. To present our case, we must understand the fundamental causes of our troubles. These are partly the result of social change, partly the result of our own fault, and partly, and I think chiefly, the result of lay interference in medical practice. For the present I shall pass the first of these three causes and proceed to consider the second and third.

To what extent has the medical profession brought upon itself the dangers which threaten it? Partly, of course, by incompetence, but this is a minor and decreasing fault. Chiefly by the practice of medicine not as a learned profession but as a trade. The distinction between a learned profession and a trade is a matter of very practical importance, already considered by the courts. Theology, medicine, and law are traditionally the three learned professions. Their practitioners are supposed to be well and broadly educated, and to act on altruistic motives. Mankind has always recognized the social value of the learned professions by granting their members special privileges. We now fear that these special privileges granted us may be taken away. They will be if the practice of medicine as a trade becomes general. What is the difference between a trade and a learned profession? I venture the following answer for medical practice: the practice of medicine as a

* Presented before the Ninth Councilor District Meeting of the Indiana State Medical Association, at Crawfordsville, on May 24, 1944.

profession requires that the first consideration of the physician be to benefit and befriend his patient—not what he may gain from him. The physician who acts on this plan under a free system of practice will occasionally be cheated out of his just compensation, but he will attain a place of honor in his community and will never want for bread. The most cogent argument against state control of medical practice is that it would destroy this powerful incentive to proper professional conduct.

Any doctor who practices medicine with gain as his primary object brings discredit on his profession. This does not imply that he should be poorly paid. The best interests of society demand that he be well paid. A man in constant need of money finds it difficult to practice the virtues essential to a useful physician—honesty, truthfulness, generosity, and independence. Society expects the physician to have wisdom, patience, skill and fortitude; to lead a respectable life, and to do nothing which will discredit his calling in the eyes of the community. If we act as tradesmen and not as physicians, society will sooner or later apply to us the restrictions it applies to tradesmen.

My subject is "lay interference with medical practice," not the misdeeds of the medical profession. I have expressed the foregoing thoughts on the latter subject to clear the way for my main topic, and to make plain that in our fight against the lay forces banded against us, we must come into court with clean hands.

Lay control of medical practice has progressed gradually and insidiously. Most physicians, even today, are unaware of its extent and sinister characteristics. Much work in medicine has been done by laymen whose motives are, beyond question, good. We owe much to lay organizations for the control of tuberculosis and cancer, national foundations to promote research, *et cetera*. No one can deny that much of this work has been beneficial. Some of it, however, has been of questionable value, despite the good intentions of its promoters, *e. g.*, the intense effort to inform the people concerning every kind of disease and its treatment, and promises of cure which cannot be fulfilled. Most laymen who really want to help medical progress are amenable to guidance by physicians. We must admit that this guidance has not always been wise.

We now consider schemes, some already in effect, others in prospect, which, if successful, will greatly limit or even take away entirely our control of medical care. These are being sponsored, for the most part, by gentlemen who view medical care as a rich prize for commercial and political exploitation—rich in money, votes, and patronage. They are also sponsored by a large group of social theorists, and by some physicians. They are inter-related and overlap each other, but may be divided, for convenience of discussion, into three groups:

1. Schemes to control hospitals.

2. Schemes for sickness and hospital insurance.
3. Schemes to socialize medical care.

Hospital Control. Control of hospitals now means control of a great part of medical care. The American Hospital Association and its constituent members have a compact organization and possess immense power which is a menace to the medical profession. The American Medical Association and the American College of Surgeons have only a feeble influence on the management of hospitals. They have little power to enforce the recommendations of their hospital inspectors. The hospital administrator usually has complete control of its financial affairs. This tends to commercialize medical care, and so leads to unethical treatment of patients.

I am not unmindful of the difficulties of hospital administrators. I accuse them, as a group, of blindness to the fundamental requirements of medical care—not of willful intention to do us harm. This blindness accounts for their not uncommon failure in the very field of business management in which they claim to be experts. They usually do not know how to get along with nurses and interns. They have inflicted upon us hospitals too expensive to build and too expensive to operate. They make hospital costs needlessly great. In most cases the hospital bill of the patient is greater than the physician's bill, and must be paid first.

Schemes for Sickness and Hospital Insurance. The hospital organizations are working in close cooperation with insurance companies which sell sickness and hospital insurance. Every critic of the management of the American Medical Association must in fairness admit that it foresaw years ago that hospital and sickness insurance might be a peril to the free practice of medicine. We have now had enough experience to know how current forms of it work. They promote the following evils:

1. Needless hospitalization: Many patients covered by hospital insurance are inclined to get the value of their money and to go to the hospital for illnesses which could safely be treated in their homes; also to stay in the hospital much longer than is necessary. How explain the provision that patients covered by sickness insurance must go to a hospital for at least eighteen hours to have an x-ray or other laboratory examination which could easily and much more cheaply be done in a private office?

2. The relegation of hospital pathologists, anesthetists, and roentgenologists to the status of non-professional hospital employees: I recently attended a meeting of the Indiana State Association of Pathologists where this question was under discussion in connection with a proposed scheme for a great extension of hospital insurance. Under this scheme the cost of the services of the pathologist was to be lumped in with other hospital expenses. A resolution was passed, calling atten-

tion of the two lonely physicians on the committee of fourteen which was framing this insurance plan, to the fact that the practice of pathology is the practice of medicine, and that pathologists are entitled to be regarded as physicians and specialists! Pathology is perhaps the most important branch of medicine. It takes many years of laborious work to train a safe pathologist. The need for well-trained pathologists is urgent. What incentive is there to a bright medical student to become a pathologist if he must surrender his status as a physician? So also for the student who thinks of becoming a roentgenologist or anesthetist.

3. The danger, as yet incipient, of the widespread introduction of contract practice to care for the policyholders of hospital and sickness insurance. The insurance companies sooner or later, if present forms of insurance persist, are certain to buy medical and surgical care at the lowest possible cost.

4. Needless treatment: Current forms of hospital insurance invite this and other forms of unethical practice.

Schemes to Socialize Medical Care. These are not an immediate danger to us. Their cost would be prohibitive; their administration next to impossible. There is no great demand for them outside of limited regions. This demand may come in the future if the forces we have been considering, and others we have but mentioned, are not checked. Revolutionary political and economic changes might bring social medicine. This would be bad, but not intolerable, provided we as a profession controlled it.

GENERAL DISCUSSION

The practice of medicine as a learned profession cannot exist if it passes under lay control. We must accept this control if it is for the general good. Our entire argument against it is based on the contention that this is not true. The evidence in support of this is overwhelming. I have already given a part of it by direct statement and by inference, and shall give more later. We now consider the questions: can we throw off lay domination? and, if we can, how?

Our Prospects. Our situation is not as desperate as most physicians suppose. We have been widely criticized, it is true, but this criticism has been for the most part in journals and books of limited circulation, and has not yet reached 95 per cent of the people. We still possess, to an astonishing degree, the confidence of the public. The present shortage of doctors has demonstrated the great love of the people for the family doctor. They are not against us. We can show them that our enemies are their enemies.

The record of our colleagues in the armed services has been splendid, and is certain to enhance the standing of our profession. Our duty is to preserve its ancient privileges till they come home.

Medicine gives an indispensable service to society. Civilization cannot exist without it. It has survived through the ages under every condition of society and under every form of government. The members of no other calling have the professional pride that physicians have. They will not as a group endure outside control for long.

Medicine in the last thirty year has attracted the very ablest young men in the country. We can safely assume that they will be able to take good care of their profession.

What We Can Do? This is a big and controversial question which I cannot discuss at length. I merely offer, for your consideration, the following ideas:

1. To drive from medicine the powerful lay groups which are exploiting it will be no easy job, but it can be done.
2. Our cause is just and in the public interest. Medical care is supporting a great growth of lay parasites. The people should know that this is what makes it expensive.
3. Our fate depends on what we can do for ourselves, not on what we can persuade politicians to do for us. We are all powerful as a learned profession which does an indispensable service for society; weak as a political pressure group. The people will support us if we act as physicians; not if we act as politicians. We need unity, professional discipline, and the will to fight. A chief danger is that laymen who profit from medical care will disrupt or control our professional organizations.
4. We must regain control of our hospitals. That the professional affairs of a hospital be made subordinate to its business management is intolerable, and even contrary to good business principles. We must oppose, with all our power, the evils of current forms of hospital insurance. My personal opinion is that the only proper form of insurance is one which pays the patient a lump sum for a given illness, to be used as he sees fit, and which also makes the total amount of insurance well below the estimated cost of the illness. To insure a house for its total value or more would be to invite arson. I regard the present provisions of these policies in giving a definite fee for a given treatment as vicious. No insurance company or any other lay agency has a right to set a value on our professional services.
5. What is for the general good is for our good. We must be ready and willing to adapt our practice to changing social conditions. We should foresee what changes are necessary and make them ourselves. We must admit and correct our mistakes. The greatest mistake of our leaders has been to allow an unhealthy growth of specialism at the expense of general practice. A third or more of all physicians are now specialists. They greatly increase the cost of medical care. Diagnosis is now sup-

posed to require a complete study of the entire patient by a group of specialists — a process entirely beyond the ability of a general practitioner.

A competent general practitioner needs to know more than any specialist — he has to know a great deal about every specialty. Very few specialists know enough to do good general practice. The general practitioner and no one else can save the medical profession. No other form of medical care can compete with that given by a good family doctor. Theorists who would socialize medical care have a very slight conception of what good medical care is. For example, they do not comprehend how much medical care has to do with the treatment of mental disturbances (50 per cent is perhaps a fair estimate). The general practitioner knows the family background of his patients, knows their personal lives, and their habits. He can treat their functional disturbances with comparative ease. He is the friend and confidential advisor of his patient. There is no substitute for him.

I favor making general practice a specialty — and the most important of all specialties; giving the general practitioner the same length of training we give other specialists, and the same certification. The Indiana University School of Medicine and the Indianapolis City Hospital have tried out on an experimental basis the training of men for general practice. More than ten years ago we

established four fellowships for this purpose at the Indianapolis City Hospital. These are filled by men who have completed a year of internship. They work for three years in all departments of the dispensary, and review the basic sciences. They learn what we think a general practitioner should know about all human complaints. This plan has been very successful.

We have also been remiss as a profession in doing little to correct the popular belief that good medical care requires a complete laboratory study of every patient who seeks the advice of a physician. This belief has been fostered by lay influence, and by the overdevelopment of specialism. It can be corrected by the improvement of general practice, and by giving proper information to the people. A good practitioner knows which patients require complete laboratory study, and which ones do not.

CONCLUSION

The great increase of medical knowledge in the last forty years has made medical care an attractive object for lay exploitation. Multitudes of laymen now make a living out of it, and threaten to take its control out of our hands. Their activities are the chief cause of the evils which afflict medical practice, unethical practices by doctors included. We must at all costs rid ourselves of lay domination. We can do this if we stick together. The people are still our friends.

INSTRUCTIONAL COURSES

The instruction courses offered for the first time at last year's meeting of the Indiana State Medical Association were so enthusiastically received by the membership that a similar program will be given at the meeting this year.

It is to be recalled that each course accommodates twenty members, and that the reservations are made in advance. Watch *THE JOURNAL* for further announcements.

PIONEER PHYSICIANS AND SURGEONS OF MONTGOMERY COUNTY, INDIANA

GEORGE T. WILLIAMS, M.D.

CRAWFORDSVILLE

(This is a continuation of the article published in the May, September and November, 1943, and July, 1944, issues—Editor's Note.)

Samuel W. Purviance, M.D., was born in Preble County, Ohio, July 29, 1823, and died in Crawfordsville, Indiana, November 10, 1910. He graduated from Starling Medical College, Columbus, Ohio, and began practice at Spartanburg, Wayne County, Indiana, where he remained eight years. In 1851 he came to Fountain City, where he continued his profession until 1866, when he came to Crawfordsville. He was a charter member of the Montgomery County Medical Society, serving as its president in 1883, and was also a member of the state society. Gentle in manner and speech, he was a safe physician and was distinguished from his fellows by his long flowing white beard.

Preston M. Layne, M.D., physician and surgeon, was born in Kentucky in 1827 and died in Crawfordsville, Indiana, in 1917. His early education was obtained, as he said, "in the woods." At the age of eighteen he began the study of medicine, soon putting himself under the instruction of Dr. S. W. Bennage. In 1855 he began practicing. His faith was of the Eclectic School and he was a member of the State Eclectic Society. He was possessed of a pleasing personality that endeared him to a large clientele. Through his long professional career he was a fine conversationalist, delightfully reminiscent of pioneer times, rich in folk lore. He was one of God's noblemen.

Willis L. May, M.D., was born in Kentucky in 1828 and died in Crawfordsville, Indiana, in 1900. He graduated from Rush Medical College in 1858. He was Assistant Surgeon of the 108th Regiment of Minute Men. He was a charter member of the Montgomery County Medical Society, a man of pleasing personality, and he enjoyed a good practice.

Joseph R. Duncan, M.D., was born in Highland County, Ohio, March 21, 1827, and spent his early life on the farm. At the age of twenty-two he began the study of medicine. After three years' study he settled at Hillsboro and Jacksonville, Indiana, and Knoxville, Iowa. In 1858 he attended the Cincinnati Eclectic College, graduating in 1859. He returned to Knoxville, Iowa, where he practiced for several years. In 1863 he was commissioned Assistant Surgeon in the Iowa Regiment. He afterward served with the 46th Regiment for three months. In 1874 he came to Crawfordsville, Indiana, and in 1877 retired because of ill health. He passed away in July, 1905.

John S. French, M.D., was born in Mercer County, Kentucky, July 13, 1829. He spent four years in Wabash College and taught school for six years. He studied medicine under Dr. J. W.

Straughan at Parkersburg, Indiana, and then attended Rush Medical College. He began practice in Waveland, Indiana. Two years later he moved to Alamo. During the Civil War he was Assistant Surgeon of Co. B, 120th Indiana Volunteers. After the war he returned to Alamo, and in 1860 he came to Crawfordsville, Indiana. He later moved to Brownsburg where he died.

Enoch E. Barnett, M.D., was reared near Ladoga, Indiana. During the Civil War he served as Captain of a Cavalry Regiment. He was captured and placed in Libby Prison, Richmond, Virginia, for a time. After the close of the war he began the study of medicine with Dr. James S. McClelland, and in 1866-1867 he attended the University of Michigan. Finishing his course there, he was for a time a partner of Dr. McClelland.

Because of failing health he started to California to recuperate, but was compelled to stop at Marysville, California, where he died and was buried among strangers. He was one of the founders of the Montgomery County Medical Society.

Mary Holloway Wilhite, M.D., was born in Crawfordsville, Indiana, in 1831 and died in 1923. She attended school sufficiently to fit herself for teaching, which profession she followed four years. In 1854 she entered Penn Medical College, Philadelphia, from which she graduated in 1856. She located in Crawfordsville, Indiana, and "nailed her sign" where it could be seen, June 22, 1856. She was the first woman from Indiana to graduate from a medical college. She soon commanded a large practice in obstetrics and diseases of children. She was the one who first suggested the County Orphans Home and never ceased her labors in that direction until the Montgomery County Orphans Home became a reality. It is now known as the Children's Home.

Enoch W. Keegan, M.D., was born in Evansville, Indiana, in 1836. He received his early education there. For two years he was in the Marine Hospital and attended Rush Medical College for two years, from which he graduated in 1861. He located in Crawfordsville, Indiana, in 1862. He was a member of the Board of Pension Examiners for six years. He was a successful physician. He was a member of the Montgomery County Medical Society, serving as its president in 1908. He died in 1914.

Mary Hoover, M.D., came to Crawfordsville, Indiana, in the early fifties. She was prominent in church circles and had an extensive practice among women and children. There is no record to

date of her birth or date of graduation from medical college. She died in 1887.

Samuel G. Irwin, M.D., was born in Pennsylvania in 1825 and died at Danville, Illinois, in 1907. In 1863 he graduated from Rush Medical College, and held degrees from Indiana Medical College, Miami Medical College and Louisville Medical College. After his graduation in 1863 he located at Mace, Indiana. In the early eighties he came to Crawfordsville, where he did a large and extensive practice for many years. I remember Dr. Irwin in his latter days. He was a large man, tall and with military bearing, and always wore a cape and high hat. With his heavy head of white hair and beard, he made an impressive figure.

Thomas J. Griffith, M.D., was born near Frankfort, Indiana, April 2, 1837. In 1846 his parents moved to Crawfordsville, Indiana, where he received his early education. During the Civil War he was Commissary Sergeant of Co. D, 135th Infantry of Indiana. At the close of the war, January, 1865, he began the study of medicine with Dr. J. S. McClelland. He attended the University of Michigan and Miami Medical College, Cincinnati, graduating from the latter school in 1867. After graduation he located in Darlington, Indiana, where he remained for twenty-one years. In November, 1888, he came to Crawfordsville, where he continued in the profession until his death in 1923. Dr. Griffith was one of the founders of the Montgomery County Medical Society and was a charter member. He was an affable, kind and polished gentleman; an earnest worker in his chosen field.

Martha E. H. Griffith, M.D., was born in Jefferson County, Indiana, November 29, 1842. She was Martha E. Hutchings before her marriage to Dr. Thomas J. Griffith, October 4, 1871. She was a graduate of the Women's Medical College of Philadelphia with the class of 1870. After marriage they located in Darlington, where she had a large rural obstetrical practice. She became a member of the Montgomery County Medical Society and the State Medical Society in 1880. After her location in Crawfordsville in 1888, she enjoyed a lucrative practice in diseases of women and children until the time of her death in 1923. She was also active in philanthropic work in the city, and an enthusiastic club woman. She was one of the founders of The Community House Association for Women and Girls in Crawfordsville, was very active in the organization, and was a member of the Board of Directors until her death. She was one of the first women to receive a diploma from a medical college recognized by the regular profession. James Barton Griffith, M.D., is a son of Drs. T. J. and Martha E. H. Griffith and is carrying on the work they left behind.

Walter L. Johnson, M.D., was born in 1842 and died in 1928. He graduated from Rush Medical College with honors, and practiced in Crawfordsville for a few years, then moved to Santa Cruz, California, where he died. He was one of the

founders and a charter member of the Montgomery County Medical Society.

Fanny McClelland Rich, M.D., niece of Dr. James S. McClelland, was born in Crawfordsville, Indiana, November 2, 1842. She graduated from the Eclectic Medical College of Indianapolis in 1875. She located in Crawfordsville after her graduation, also practiced in Frankfort and Lafayette, Indiana. She did a general practice and was especially successful in the treatment of diseases of women and children. She died in Crawfordsville on April 25, 1921.

Thomas F. Leech, M.D., came to Crawfordsville in the eighties for the practice of medicine and surgery. He was a Surgeon in the Navy during the Civil War. He served as vice-president of the Indiana State Medical Society in 1893-1894. He was very efficient, being a graduate of Jefferson Medical College with the class of 1866. After the graduation of his son, Charles, from Wabash College, he moved to Chicago.

Oliver H. Jones, M.D., was born in 1843 and died in 1913. He was a graduate of Miami Medical College, of Cincinnati, in 1873. He was in practice here for thirty years or more. He was a gentleman of the old order and professionally stood high with his conferees. He enjoyed a splendid practice. His passing was a great loss. He was a delegate from Montgomery County to the Pan American Medical Congress held in Washington, D.C., in 1893.

Jesse N. Talbott, M.D., was born in Quincy, Illinois, August 15, 1840 and died in January, 1908. He served in the Union Army during the Civil War. He was a graduate of Miami Medical College, Cincinnati, with the class of 1875. He practiced at Jacksonville and Alamo, Indiana, before coming to Crawfordsville in the nineties.

Elliot Detchon, M.D., was born in Portage County, Ohio, March 15, 1828 and died in Crawfordsville, Indiana, January 29, 1905. He began the practice of medicine in Romney, Indiana, in 1851. He later went to New Richmond, Wingate, Newtown and Crawfordsville. In 1871 he entered the retail drug trade which he followed for twenty years.

Fred F. Montague, M.D., was born in Erie County, Ohio, June 18, 1840. When seven years of age his parents made an overland trip to California and returned by water to Detroit, Michigan. During the Civil War he enlisted as a hospital steward in the 4th Michigan Cavalry, serving for the duration of the war. He was a graduate of the American Eclectic College. He began practice in Detroit, Michigan, in 1867 and came to Crawfordsville in 1876, remaining here until his death in 1894.

Samuel Leonard Ensminger, M.D., was born in 1844 and died in 1921. He was a graduate of Miami Medical College with the class of 1874. For many years he was a surgeon for the Monon Railway and was a member of the Monon Surgical Society. He was a member of the Sounty Medical Society, the State Medical Society and the American Medical Association. Dr. Ensminger stood for

high ideals, but he wanted honesty, especially from those in the medical fraternity. He was a good man and a safe surgeon. Dr. Leonard Ensminger, noted surgeon of Indianapolis, who is listed in the first edition of *Who's Who Among Physicians and Surgeons* published in 1938, is a son of the above sketch.

William Beaty Chambers, M.D., was born December 27, 1856, and died May 26, 1910. He was a graduate of the College of Physicians and Surgeons of St. Louis, in 1881. He located in Crawfordsville where he practiced for twenty-six years. He was very active professionally. He was a member of the County Medical Society for many years, also served as city health officer for two terms, and was a member of the City Council one term. Politically, Dr. Chambers was an ardent Democrat.

Alexander Peter Fitch, M.D., was born in Staunton, Virginia, September 9, 1845, and died at Crawfordsville, Indiana, December 6, 1918. He graduated from the Washington University School of Medicine, Baltimore, Maryland, in 1871. In 1874 he located in Waynetown, Indiana, where he practiced until 1886, when he was appointed physician to the Yankton Indian Agency at Yankton, South Dakota. Upon his return to Indiana he located at Lebanon, continuing the practice of medicine, and was surgeon for the "Big Four" Railroad. In August, 1910, he accepted the appointment of assistant medical examiner for the Ben Hur Life Association, Crawfordsville, Indiana, where he remained until his death. He held membership in the county and state societies and American Medical Association.

BRITAIN'S GOVERNMENT HEALTH PLAN

(Taken from the Transatlantic Edition of Daily Mail)

Legislators Approve Government's New Health Charter

"The British Government's proposal to establish a national health service to provide free for everybody in Britain the best and most up-to-date medical advice has been approved by the House of Commons. The scheme will include every possible facility—general practitioner, consultant, specialist, institutional, dental, surgical, home-nursing, and midwifery. The basic aim of the great medical charter is to 'encourage a new attitude toward health.'"

Thirty Thousand Doctors Ask to Give Verdict on Plan

"How Much Should You Be Paid?"

"The British Medical Association has sent to each of the thirty thousand doctors of Britain a questionnaire dealing with the Government's new health plan. When the replies have been received and analyzed, the association will state the doctors' attitude toward the State Medical Scheme.

"The questions give doctors full opportunity to express sympathy or dislike of the Government proposals.

"Here are the principal questions:

"1. Should a national health service be confined to 90 per cent of the public, leaving out the 10 per cent in the upper income group (as advocated by the British Medical Association), or should it include everyone, as the Government proposes?"

"2. The Government proposes that complete hospital and specialist services shall be available to every one in a general ward, free of charge. Do you agree or disagree?"

Your Children

"3. How much, with all expenses paid, do you think a general practitioner of forty should get from all sources? How much should a consultant or specialist of the same age get from all sources?"

"4. Would you care to give the occupation or profession of your father?"

"5. If a national health service, as contemplated by the Government, is introduced, would you regard medicine as an attractive profession for your child?"

"6. Do you think the quality of the country's medical service will be enhanced or will suffer?"

"7. Are your reactions to the Government plan favourable or unfavourable?"

Your War Bonds have reverberated in Tokyo and Berlin:

Says Tojo: "So sorry, we can not win the war."

Says the German War Lords: "We have lost the war—down with Naziism!"

THE CADET NURSE ANSWERS THE NEED

With an urgent call for ten thousand additional nurses for the Army within the year, and a new quota soon to be set by the Navy, Indiana is faced again with the need for recruitment of nurses for the armed forces. This can only be accomplished if the new supply fills the gaps made by those who enlist.

The Cadet Nurse is the answer to this dilemma. Under provisions of the Bolton Act, introduced by Congresswoman Frances P. Bolton of Ohio, and unanimously passed in both houses of Congress in the spring of 1943, the Cadet Nurse Corps was created. The bill provides for all-expense scholarships in approved schools of nursing. Scholarships cover tuition, living expenses, books, uniforms and all fees. The cadet nurse is free to choose her own school of nursing and is given an allowance of fifteen dollars per month for pre-cadets to a minimum of thirty dollars per month for senior cadets. In return the cadet pledges to remain in essential nursing, civilian or military, for the duration of the war.

In order to accelerate their education, courses for the cadets provide complete preparation in twenty-four to thirty months. The pre-cadet period is nine months, and the junior cadet period twelve to twenty-one months. Many states permit graduation after twenty-four to thirty months. In states requiring thirty-six months for graduation, a senior cadet period is provided, during which time the cadet is given important assignments under supervision.

A wide field of service is open to the graduate

nurse with special preparation. In some instances the young cadets begin their training in military hospitals, such as Billings General Hospital, Fort Harrison, where they have been training for some time. Never before have the opportunities for service been as varied and attractive as they are now during the war. The Cadet Nurse may specialize in public health, child health, orthopedics, teacher training or a vast number of other fields. After the war she will be in a position to work abroad or at home in rehabilitation, nutrition, psychiatry, public health, or she may choose the career of wife and mother, where her training has prepared her to do a superior job.

While the United States Cadet Nurse Corps was established as a war measure, and as such is doing much to relieve the present shortage, the program will not stop abruptly with the declaration of peace. Young women enrolled in the Corps ninety days before the war ends will be entitled to complete their nurse education under the Corps program.

The United States Cadet Corps fulfills three important functions. It offers a means of recruiting new students, thereby materially assisting the Red Cross recruitment program, which must of necessity take the experienced graduates. Because of the Corps, hospitals without schools of nursing are provided with more nursing service through the use of senior cadets, and schools of nursing are enabled, through this program, to expand, thereby benefitting physicians, hospitals, the nursing profession, health agencies and the public.

COVER PAGE

The photograph on the cover page is that of a professional model. Ruzzi Green, nationally-famous photographer, made this picture for the United States Cadet Nurse Corps. The Public Health Service has approved the use of the picture as a cover page for our magazine. We are grateful to Albert L. Ramsay, Assistant Chief, Division of Poster Clearance and Allocation, and to Jean Henderson, Chief, Public Relations Section, Division of Nurse Education, United States Public Health Service, for making it possible for us to reproduce this photograph.

UNITED STATES CADET NURSE CORPS

"The United States Cadet Nurse Corps training program, established by the United States Public Health Service, as an emergency measure, is designed to help supply the greatly increasing needs for professional nursing care in the military forces and the civilian population. Because of the shortage of trained nurses it is quite necessary at this time to have a decided increase in the number of student nurses who should seek this type of training. It is our duty and obligation to encourage the enlistment of well qualified young women to participate in this patriotic service.

"JAMES E. PAULLIN, M.D.,
Past-President,
American Medical Association."

(Quoted from the Information Program for the United States Cadet Nurse Corps.)

REHABILITATION OF THE BLIND

One hundred years ago the only occupation open to the blind was that of begging. Today there are 214 known economically-feasible employment opportunities open to the blind who meet the following prerequisites of eligibility for employment:

1. Physical fitness save for blindness.
2. The innate and developed abilities of the candidate along specific and practicable lines.
3. The ambition, desire, and enthusiasm for work.
4. The ability of the candidate to get along well with his seeing fellowman.
5. Virtual independence in traveling.

A study based on the data obtained from 256 organizations in the United States, employing 1,084 blind persons indicate that when the above five

factors are given proper consideration, the blind can and do compete with the seeing in speed, accuracy and efficiency. Pity and sympathy will not make the blind see again. The true calamity of the loss of sight is not merely the exclusion of sunlight but the enforced inactivity that usually attends. The hardest day's work a man ever does is a day of nothing; therefore, the best way for you to help the blind to help themselves is through employment on a competitive basis.

Returning blind veterans of the armed service will want the opportunity to be employed in industry. The United States Army is providing training in rehabilitation centers for the blind, and industry should provide employment for the trained man.

Two Hundred Ten Known Competitive Employment Opportunities Now Being Held by Physically Capable, Legally Blind Persons in the United States

Clergyman	Piano Tuner	Tube Flaring Machine Operator	Furniture Packer II
Teacher, College	Broom Maker	Charging Machine Operator	Gas Tank Assembler
Electrical Engineer	Salvage Inspector	Stranding Machine Operator	Gear Assembler
Mechanical Engineer	Propeller Mechanic	Cleaner, Tools	Graphite Sprayer
Lawyer	Radio Repairman	Bearing Inspector	Grinding Machine Operator IV
Concert Singer	Maintenance Man, Building	Bender, Machine	Grommet Machine Operator
Teacher, Music	Oyster Slucker	Tube Bending Machine Operator	Hack Saw Machine Operator
Case Worker	Needle Straightener	Riveter, Aircraft	Hand Press Operator
Teacher, Grade School	Needleboard Repairman	Crystal Grinders	Helper III
Teacher, High School	Bobbin Inspector	Record Finisher	Labeler, Hand
Tutor	Splicer, Rope	Record Tester	Labeler, Machine
Instructor, Physical	Dry Cans Operator	Armature Winder	Laborer, Coffee Industry
Radio Operator	Thread Inspector	Coil Winder II	Laundryman I
Employment Interviewer— Placement Secretary	Garnett Machine Operator	Coil Assembler	Lead Assembler
Information Clerk	Hat Brusher	Coil Shaper	Lidder
Transcribing Machine Operator	Die Cutter	Micrometer Inspector	Machine Operator
Stock Clerk	Mangler, Knit Goods	Twisting Machine Operator	Meat Packer
Tool Clerk	Riveter, Hand	Detail Assembler	Motor Assembler
Telephone Operator I	Riveter, Machine	Final Assembler	Packer II
Salesman, House to House	Parachute Repairman	Riveter	Packing Supply Maker
Salesman, Insurance	Glue-man III	Plumber Helper	Parts Winer
Sales Clerk	Nailing Machine Operator	Parachute Packer	Pianist
Counter-man, Lunchroom	Mattress Filling Machine Operator	Filling Machine Operator	Pickling Operator
Bus Boy	Tufting Machine Operator	Packer, Ammunition	Pin Boy
Pot Washer	Stapler Operator	Carton Packaging	Power Press Operator II
Dishwasher, Machine	Strapping Machine Operator	Candy Wrapper	Power Screw Driver Operator
Racker—Pool Room Attendant	Box Maker, Cardboard	Valve Assembler	Roving Stockman
Janitor	Bag Maker	Grinding Wheel Dresser	Sack Cleaner
Porter I	Heel Builders	Film Inspector	Sander
Elevator Operator, Freight	Lacer	Blueprint Trimmer—Folder	Sausage Packer
Beckeeper	Last Puller, Machine	Laborer, Machine Shop	Sewing Machine Operator
Farmer, Poultry	Glass Cutter	Oiler I	Shear Operator
Net Maker	Buffer	Auto Washer	Sheet Metal Former
Mattress Maker	Polisher	Assembler	Shipping Room Helper
Weaver I—Rattan Worker	Burrer, Hand	Bead Stringer	Shirt Starcher
Bookbinder	Milling Machine Operator, Automatic	Bearing Scraper	Sorter, Machine Shop
Heel Trimmer	Boring Machine Operator	Bobbin Cleaner	Stamper
Machinist, Bench	Multiple Spindle Drill Press Operator	Bobbin Cleaner, Hand	Threading Machine Operator
Tool Inspector	Single Spindle Drill Press Operator	Body Wireman	Tool Kit Packer
Turret Lathe Operator	Tapping Machine Operator	Bonderizer	Truck Loader
Boring Mill Operator	Thread Milling Machine Operator	Box Bundler	Truck Unloader
Filer, Machine	Screw Machine Operator	Box Maker, Wood	Tube Roller
Honing Machine Operator	Lathe Operator, Automatic	Box Stitcher	Washer, Metal
Sheet Metal Worker	Reaming Machine Operator	Capping Machine Operator	Waste Bagger
Coremaker	Knurling Machine Operator	Cording Boy	Weigher
Fitup Man, Boilermaker	Lapping Machine Operator	Electrician Helper	Welder, Spot
Tube Drawer	Floor Assembler	Feeder	Wire Brushman
Radio Equipment Assembler, Special	Gager	Flat Work Catcher	Wire Stripper
Magnet Winder	Sandblaster	Floor Girl III	Wrapper
Rotor Assembler	Riveter, Pneumatic	Foot Press Operator	Yardman
Electrical Assembler	Arbor Press Operator	Freight Handler	
Electrical Instrument Repairman	Punch Press Operator		

(This information was supplied by the Pennsylvania Institution for the Instruction of the Blind.)

FEDERAL INCOME TAX

"THE INDIVIDUAL INCOME TAX ACT of 1944, which was passed by Congress a few weeks ago, is described as 'an Act to provide for the simplification of the individual income tax.' 'Although it does contain several simplification features, it also contains some new complications, as for example, a new concept called 'adjusted gross income' was introduced. Another is the optional standard deduction.' One item that should not be overlooked is the fact that a *new* type of exemption certificate must be secured from each employee before the close of 1944, and certain changes in accounting and payroll records will have to be made before the first payment of salaries in 1945. A brief summary of some of the main changes in the new law is as follows: (a) The Victory Tax is

repealed, but it is replaced by a new 3 per cent normal tax. The new surtax rates combine the former normal and surtax rates. (b) A new simplified tax table provided in Supplement T may be used by taxpayers having 'adjusted gross incomes' of less than \$5,000. (c) A uniform per capita exemption of \$500 replaces the former allowances for personal exemption, head of family and credit for dependents. (d) A new definition of a 'dependent' is introduced. Age is no longer a factor. Hence, a son in college, if he receives more than half of his support from his father, is a dependent. It is not too early now to begin familiarizing yourself with what the Federal Government will expect of you before the end of 1944, both as an employer and as an individual income taxpayer."—*Academy of Medicine of Cincinnati, Monthly Letter.*

THE STATE CONVENTION

Don't forget the annual State Meeting, to be held on October 3, 4, and 5, at the Murat Temple in Indianapolis.

Arrangements have been completed for an outstanding scientific program with emphasis on Military and Aviation Medicine.

Put these dates down on your calendar, and we assure you that you will not be disappointed.

COMMITTEE ON CONVENTION ARRANGEMENTS

BERT E. ELLIS, *Chairman*

WALTER MOENNING,

GORDON BATMAN



Military News



Major R. G. Ikins, of Lafayette, has been transferred from Chicago to Camp Ellis, Illinois.

Captain Ernest L. Dietl, of South Bend, arrived in England shortly before Easter.

Lieutenant William B. Ferguson, of Indianapolis, has been transferred from Carlisle, Pennsylvania, to Camp Stewart, Georgia.

Through a change-of-address notice we learn that Captain Larkin D. Denton, of Greentown, has recently moved to Camp Blanding, Florida.

After serving overseas, as indicated by his San Francisco A.P.O. address, Captain C. J. Aucreman, of Montpelier, has been transferred to Randolph Field, Texas.

Captain Walter W. Meade, of Bicknell, is stationed at Camp Ellis, Illinois, where he is in command of a "medical train," designed to handle the evacuation of combat wounded to base hospitals.

After completing a two-year residency in surgery at the City Hospital, Doctor Joseph R. Eastman, Jr., of Indianapolis, was recently commissioned a lieutenant in the Navy and has left for the United States Naval Hospital at Shoemaker, California.

A V-mail letter from Captain Charles P. Anderson, of Gary, tells us that he has been moved to another address, still a New York A.P.O.; but that, being an optimist, he hopes to be home for Christmas. He adds that he isn't sure which Christmas it will be.

The latest word from Captain Thomas W. Johnson, of Indianapolis, is that he is still in England with a station hospital. Captain Johnson is doing E.N.T. work, which was his specialty. He has had some interesting experiences, but finds censorship limiting in regard to telling anything exciting.

For the past eighteen months, Lieutenant W. D. Buchanan, of Bremen, has been in French Morocco, Africa. He recently flew back, and after spending a few days in Indianapolis he will go to the Philadelphia Naval Hospital, where he will do radiology for the next six months. Lieutenant Buchanan has seen many Indiana men in Africa, among whom were Major Herbert L. Sedam, Major Kenneth E. Thornburg, and Captain Don E. Kelly—all of Indianapolis.

Captain Jack McKittrick, of Washington, is stationed in England. He is a flight surgeon with the Eighth Army Air Force.

Dr. H. F. Kobrak, of Gary, has been promoted to a major and assigned to duty aboard a transport. Major Kobrak was previously stationed at Camp Adair, Oregon.

Captain Clarence G. Kern, of Lebanon, has been appointed chief of medical service at an Army Air Force regional station hospital at Ellington Field, Texas.

After spending a three weeks' leave with his family in Lafayette, Major George R. Donahue has been assigned to Camp Atterbury. He recently returned from Greenland, where he was commanding officer of a station hospital.

Lieutenant Commander H. H. Ash, of West Lafayette, has returned after about two years of foreign duty with a Naval Mobile Hospital, at New Caledonia. After a three weeks' leave, he reported for duty at the Great Lakes Naval Training Station.

Lieutenant Robert M. Hansell, of Indianapolis, has been assigned to the station hospital at Fort Knox, Kentucky, as a member of the Physical Examining Board. Also located at Fort Knox are Major Richard Bloomer, of Rockville, Major Alan Sparks, of Indianapolis, and Major Carl Trout, of West Point.

Well satisfied with his set-up, Major Leo L. Grzesk, of Mishawaka, who is on duty in the South Pacific, reports that he lives in a thirty-two by twenty tropical cabin, which is completely screened. He says even the general is envious; they call it "The House of Lords." Major Grzesk further states that the food is good, and that he has a radio which brings in everything, including baseball.

After long service in the Pacific, Major William Barnett has been returned to the United States, and has spent a short leave in Logansport. Major Barnett has been recovering from an illness contracted in Australia but has now been assigned to duty at Hot Springs, Arkansas. In speaking of tropical diseases, Major Barnett is quoted as saying: "Parts of New Guinea were among the worst portions of the world for tropical diseases . . . they are now comparable to the metropolitan cities of Panama." He praised the value of blood plasma, and stressed the need for a continuing supply.

Major James T. Pebworth, of Indianapolis, has been transferred from Camp Cooke, California, to a San Francisco A.P.O. address.

Major W. C. Smullen, of Rushville, has left Camp Cooke, California, and evidently embarked for an overseas post.

West Palm Beach is again the location of Captain Kenneth L. Shaffer, of Vincennes, who has been transferred there from Randolph Field, Texas.

Captain Frank W. Peyton, of Lafayette, was recently awarded a ribbon with three bronze stars for participation in the North African campaign, the Sicilian invasion, and the Italian campaign. He has been stationed with an evacuation hospital at the Anzio Beachhead, but is now pushing on into Italy with the Fifth Army.

Colonel Will W. Holmes, of Logansport, who has been on a special mission with the Chinese army, as well as having been at other Shangri Las during his three and one-half years in the service, is now medical officer of the Replacement Pool at Fort Benjamin Harrison. After the war he will have some interesting tales to tell, but the star and service ribbons which adorn his uniform must tell the story for the present.

From Captain Harold Zimmerman, of Evansville, who is stationed in England, comes the following news: "Most of us in this theatre are fairly comfortable and have managed to intersperse sight-seeing trips on foot, bicycle, or train into the routine medical officer's life. The weather of late has not been unlike that of the States, and we find that a goodly number of the local citizens speak a language that resembles ours. However, it would seem that something is in the wind that promises a change in tempo as well, we hope, as an early climax to all this." (Captain Zimmerman's letter was dated June fourth.)

For more than a year Major Frank J. Kendrick, of Gary, has been seeing a great deal of the world aboard a troop transport as transport surgeon. Major Kendrick states that the work is somewhat different than it was before he entered the Army, a good example being the difficulty of operating in rough weather. Sometimes it was necessary to tie the table to the floor, and himself to the table, which still left his instruments free to skid around alarmingly. He says that the larger ships ride fairly easy, even in storms. Another feature is that a transport surgeon's aids are the men being shipped to overseas duty, each trip consequently seeing him heading an entirely new set of physicians. He adds that assorted bomber and submarine attacks provide further diversion. After the war is over he will, no doubt, have some interesting stories for his colleagues.

Another newcomer to the armed forces is Lieutenant Charles F. Gillespie, of Indianapolis, who is serving with the Army Medical Corps. He will be stationed at Carlisle Barracks for the next few weeks.

Lieutenant Colonel David H. Sluss, of Indianapolis, recently returned from duty in Persia. He was stationed for a short time at Fort Benjamin Harrison, but has now gone to Camp Barkeley, Texas.

The United States Army General Hospital at Camp Atterbury has been designated as the Wackman General Hospital, it has been announced by Colonel H. L. Conner, commanding officer of the hospital. The War Department named the hospital in honor of the late Colonel Frank Bolles Wackman, Hoosier scholar whose death was reported in our June issue.

A report from an Associated Press correspondent includes Major Charles L. Richardson, of Rochester, as being one of the many Army doctors who participated in the invasion of France. Major Richardson is on duty in a surgery tent somewhere in the St. Lo Sector. In describing the surgery tent the correspondent said, "Three pairs of wooden horses were the operating tables, supporting the stretchers on which the patients lie."

AWARDED THE LEGION OF MERIT

Colonel Franklin T. Hallam, M.C., United States Army (of Indianapolis), has been awarded a Legion of Merit. The following is a true copy of his citation:

"By direction of the President, under the provisions of the act of Congress approved 20 July 1942 (sec III, Bull 40, WD, 1942), Executive Order, No. 9260, 29 October 1942 (sec I, Bull 54, WD, 1942), and authority contained in War Department radiogram dated 8 February 1943, a Legion of Merit is awarded by the Commanding General, United States Army Forces in the South Pacific Area, to the following-named officer:

"FRANKLIN T. HALLAM, (0-328036), Colonel, Medical Corps, United States Army, for exceptionally meritorious conduct in the performance of outstanding services as Surgeon of a corps in the Solomon Islands from 28 February 1943 to 31 March 1944. At Guadalcanal, where he contributed much to substantially decrease the malaria rate, Colonel Hallam was responsible in a considerable measure for the organization and coordination of joint Army and Navy medical services. Later, he was of invaluable assistance to the corps Commander in planning and executing the initial evacuation program in connection with combat operations at New Georgia. Through his efforts in this campaign, rest camps were established and so expertly operated that hundreds of patients suffering exhaustion and nervous disorders were rehabilitated and returned to combat units in a minimum of time. Colonel Hallam's services again were distinguished at Bougainville where he was largely responsible for the efficiency of medical installations and for effective malaria control. Entered the military service from Indiana."

Italy's rainy season seems to be over, according to two South Bend doctors, Captain Raymond E. Nelson and Captain Casimir L. Libnoch. Captain Nelson says, "I am managing to keep fairly busy and am getting plenty of Italy's famous sunshine. The sea is still a bit cool for bathing, but I hope to get in some of that before too long." And Captain Libnoch states, "I drag my forty-two medics up and down the mountains and take sunbaths in an apricot orchard. Guess I'll be in good shape on returning up front."

THE JOURNAL office recently received a V-mail letter from Major Paul L. Long, of Anderson, from which we quote: "Delivery of my JOURNAL has been rather poor of recent months since my APO has changed about four times since January, so I wonder if you will correct the mailing list, at least temporarily."

"Thus far I have met George Balsbaugh and Eugene Cook, from North Manchester, Robert Butterfield, from Muncie, and Voris McFall from Anderson. I also ran into Robert Walker when in New Zealand."

"While nothing like the European theatre, we have seen enough action to satisfy any longing for excitement." (Major Long's letter does not disclose his whereabouts, other than that he has a San Francisco A.P.O. address.)

Following is a letter which we take the privilege of quoting from the *St. Joseph County Bulletin*. It was written by Dr. Earl E. Parker, of South Bend:

"Just a line tonight while I am in the letter-writing business. I suppose you know that I am in New Guinea. But I'm here to tell you it isn't nearly the romantic place I've heard of. The only grass skirts you see are those lying on a table somewhere. We are only one of a number of general hospitals, and someone casually told us today that it would probably be from five to eight months before we would see a patient. Can't you see how much we will know by that time? Our lot here is not so bad, however. We live in tents, but my roommate and I have built a wooden floor in it, and have a nice table to write on and boxes to sit on. Now we just sit and watch it rain. I haven't met any doctors from near South Bend. If you know of anyone with the same APO, I would certainly appreciate having their names. I will do my best to find them. That goes for anyone besides doctors, too. Certainly miss all the folks at home. Wish I could drop in on all of you. I'd be very glad to hear from you."

Lieutenant Commander Jesse S. Spangler, of Kokomo, has been transferred to the Bunker Hill Naval Station after eighteen months of duty as chief surgeon of the naval hospital in Casablanca. In that capacity he operated upon wounded cases of all nationalities, including Greeks, Yugoslavs, and French, and British and American soldiers. Commander Spangler said the hospital was well-equipped, and that a much-used instrument was the Berman locator to detect pieces of metal that lodge in the bodies of wounded men. "It was a great experience, one I would not have wanted to miss," Commander Spangler is quoted as saying, "but I am most happy to be home again."

We have received a letter from Captain Hugh S. Ramsey, of Bloomington, from which we glean some interesting news items: "I'm well and have been with this unit about one month. Am in the Ninth Air Force now. When I came over in early July, '42, was with an Engineer Regiment, but was transferred to the Eighth Air Force in May, 1943. Feel rather fortunate being assigned to a hospital for a change."

"Haven't seen Colonels Cyrus Clark and Charles Thompson and their outfit since last fall, but they're still around somewhere. Major Maurice Glock, of Fort Wayne, is now in the Chief Surgeon's Office, ETOUSA. We were in the Engineers Regiment together. Keep up the good work." Captain Ramsey is with a field hospital.

An informative letter has been received, by Dr. John R. Brayton, from Captain Phillip E. Yunker, of Evansville. We quote in part: "Well, here I am, somewhere in New Guinea. Had a most delightful trip without a trace of sea sickness. Took sun baths on deck every day and acquired quite a tan. The sun gets pretty hot over the equator. It is winter here and the rainy season is on. The heat is terrific in the day, but it is cool enough in the evening for a wool blanket. The dew is unusually heavy and penetrates into the tents. Clothes are damp in the morning. The natives are a queer lot of people: five feet, average height, good muscular physiques, and old-appearing faces. As they get older their skin is covered with various scars from disease—pot bellies with enlarged spleens. Loin cloth or pieces of cloth draped over the waist down constitutes the clothing."

Hi, Medico!

The picture on the cover of this month's copy of THE JOURNAL should be of particular interest to you. This beautiful and attractive young lady is "MISS MEDSOC," our "pin-up girl." Some day she may catch up with you in one of your hospitals. A couple of months from now MISS MEDSOC is going to write all of you a letter in the MEDSOC series.

It is a great pleasure to introduce to you our "MISS MEDSOC."

Yours 10-derly,

MEDSOC

Captain Robert H. Wiseheart, of Lebanon, is located with a field hospital somewhere in Russia. When assembling supplies for the first American planes to be operated out of Russia, he came across some bandages which had been packed in Lebanon by his wife. Suffice it to say, we are sure he is convinced of the value of the work being done by the Woman's Auxiliary, as well as the many other organizations assisting in Red Cross work.

From England, Major Earl W. Mericle, of Indianapolis, writes: "Have been in the E.T.O. for the past five months, and have missed the last two copies of THE JOURNAL. For a considerable time I was located near our Indiana group, and had the pleasure of seeing the Indiana medical officers there.

"This country is interesting in many ways. After so long one doesn't notice the British accent, and driving on the left side of the road seems normal. Rogers Smith would love these highways, as they are all made up of north and south speedway turns.

"As psychiatrist to this division, I am equipped with an ophthalmoscope, six tuning forks and one percussion hammer (British style). Have a three-fourths-ton truck to get about in, and the examining room may be a mess hall, a tent, or barracks, as the situation permits."

THE JOURNAL is in receipt of the following letter from Captain Gerald Shortz, of Kendallville: "I am writing this note to express my appreciation of receipt of the Indiana State Journal for the past twenty months of overseas duty. I have particularly enjoyed the Military News section, which has kept me informed in regard to the location of various state doctors with whom I am acquainted.

"During these past twenty months I have served as an anesthetist on a general surgical team of an auxiliary surgical group. This service has led to various experiences which include two amphibious operations in the Mediterranean Theatre. My thirst for adventure and excitement has been fully satisfied, and I am now ready to enjoy the peaceful life at home.

"In the early stages of our work, plasma proved itself a valuable adjunct in treating the severely wounded, but it was soon evident that there was no substitute for whole blood. This need was met by forming fixed blood banks for large hospitals and mobile blood banks for small mobile hospitals. We have been using on the average of 2,000 cc. whole blood per patient pre-operatively. The blood used in the majority of cases was type "O" of low titer. Rarely have we seen a transfusion reaction.

"Now that the big league circuit has swung to northern France, we in the minor leagues are watching their progress and are hoping that they grab the bunting in a short and snappy series."

Captain James R. Ware, of Andrews, now has a San Francisco A.P.O. address. He was formerly stationed at Farmville, Virginia.

We believe the following letter will be of unusual interest. It was written by Captain R. W. Holde-
man, of South Bend, and is reprinted from the *St. Joseph County Bulletin*:

"I am OD tonight, so I have a little time to write letters that I might not write another time. I did not read that resolution thoroughly that was published in the *Bulletin* about the pathologists keeping separate in the insurance scheme, and I do not know of the bill which it referred to, but I do know what has happened over here. It is my good fortune to be in a unit which has been invited into the hospitals here, and we have worked in the civilian hospitals and have attended the clinics as they are run. How much has been modified by the war we are not able to determine, of course. I do not believe anyone can get an idea of how the British system works unless they watch it; I do not think it can be understood by reading about it. There seem to be no private patients as we know them. However, there are only a measly twelve thousand that are covered by the Panel System. The G P (little letters as far as I can see here), I understand, makes from thirty to sixty calls a day. He tries to refer all his sick patients to the hospital, I am told. He has surgery hours daily for two or three hours (surgery equals office). Some of them dispense drugs and collect from the insurance for that, and they can all write Rx which the chemist-druggist fills. They both collect from the National Health Insurance. If the patient also belongs to a hospital insurance scheme, he goes to that hospital; if not, he goes to a municipal hospital, which is a charity hospital. The men who work in that hospital are honoraries and are paid a salary. They usually make rounds two or three times a week. The house man does the rest. He is similar to our intern or resident, but he is not an exact parallel. If the patient has an insurance scheme or can pay some of his expenses, he is sent to a voluntary hospital which is supported entirely by donations. The person pays what he can; if it is enough to get a semi-private room, the honorary staff collects what it can, otherwise they get nothing. The voluntary hospital has an out-patient department which is also run by the voluntary staff man in which he sees what patients the G P wants a consultation on, and he then sends a note to the G P. They are very careful about this. Some girl is usually standing around to take dictation. There is no consultation fee for this either. Of course, not everyone is on the panel, and it seems to me that the consultant must really charge to make the nice living he apparently does. We have been in some of their homes and they are nice, nothing exceptional by our standards, however. As yet I have not seen or heard of many consultants. They do very little laboratory work. They depend mostly on physical diagnosis, at which they are very good. They do not confirm their mistakes by autopsy very often. In two hospitals, at least, that I have had occasion to observe they do not send their surgery specimens to the laboratory very often. They do confirm the Ca., however, since there is a very good cancer clinic close by which treats a large number of cases. I met a Dr. Patterson of whom you may have heard. Dr. Jefferson does considerable brain surgery. A Dr. Branwell has written several books. Some of the medical societies are going in favor of the new socialization plan while other societies vote against it. I am not sure how the majority feel about it. I don't think the G P cares for the proposed new plan; the consultants vary in their opinion. There was a great shortage of physicians here, even before the war, and they are wondering how they will make up the shortage. They all like the pension part of it. Don't let us get in the mess they are in over here!"

Deaths

John Asa Gibbons, M.D., of Mitchell, died July sixth at the age of seventy. He graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1898.

Ralph Waldo Emerson, M.D., of Owensville, died suddenly on July third, at the age of seventy-four. Dr. Emerson was a graduate of the Eclectic Medical College, Cincinnati, in 1898.

Orris G. Cruikshank, M.D., of Terre Haute, died on June seventeenth at the age of eighty-three. He was a graduate of the Central College of Physicians and Surgeons, Indianapolis, in 1898. He had retired from practice.

Basil Mitchell Taylor, M.D., of Portland, died of a heart attack at his home on July tenth. He was seventy-four years of age. Dr. Taylor was a graduate of the University of Louisville School of Medicine, in 1892. He was especially interested in pediatrics. Dr. Taylor was serving as secretary of the Jay County Medical Society, an office he had held for many years. He had also served as city health officer for several years. He was also a member of the Indiana State Medical Association, and the American Medical Association.

Elias H. Brubaker, M.D., of Flora, died June twenty-eighth, after a short illness. He was sixty-three years of age. Dr. Brubaker graduated from the Medical College of Indiana, in Indianapolis, in 1905, and had practiced for the past thirty-seven years in Flora. Dr. Brubaker was a member of the Carroll County Medical Society, and had served for many years as its secretary. He was also a member of the Indiana State Medical Association, and had served on several committees. He was a Fellow of the American Medical Association.

Frank F. Tourner, M.D., of Bloomington, died at his home July sixth. He was eighty-five years of age. Dr. Tourner graduated from the Kentucky University Medical Department, in Louisville, in 1899, and had practiced nearly fifty years in Bloomington before retiring two years ago.

John Henry Gilpin, M.D., of Cheboygan, Michigan, died at his home on June twenty-third, at the age of sixty-eight. He graduated from the University of Michigan Medical School, in Ann Arbor, in 1902, and a few years later came to Fort Wayne where he practiced until eight years ago, at which time he moved to Cheboygan. During that time he had served as president of the Fort Wayne Medical Society and the Twelfth District Society, and also as city health commissioner. For a time he served as superintendent of the Soldiers and Sailors Home at Lafayette.

Charles E. Caylor, M.D., of Bluffton, aged seventy-four, died at the Clinic Hospital, at Bluffton, on July fifth, from a skull fracture and other injuries suffered in an automobile accident twelve hours before. Doctor Caylor was a native of Wabash County and obtained his medical education at the Kentucky School of Medicine, Louisville, from which he graduated in 1893. He began his practice in Nottingham, Wells County, later moved to Pennville, and established his practice at Bluffton twenty-six years ago, where he founded the Caylor-Nickel Clinic which, with the Clinic Hospital he headed as chief of staff until his death, stand as a living monument to a forward-looking man.

Dr. Caylor was the dean of the Wells County Medical Society, having served as its president in 1895. He was a member of the Wells County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association. He was also a member of the Southern Medical Association.

ABSTRACT: LEUKEMIA INCIDENCE AMONG DOCTORS

Leukemia may occur in workers with radiation from x-ray or radium under conditions like those in which cancer of the skin due to radiation can arise, *The Journal of the American Medical Association* for April 15 points out. Exposure to x-rays under experimental conditions favors the development of leukemia in animals. Since high energy radiations may play a part in human leukemia, workers in the National Cancer Institute have compared the incidence of leukemia in physicians and in the general population on the basis of the death lists of physicians in *The Journal*, the mortality reports of the United States Bureau of the Census and an unpublished

compilation of the United States Public Health Service. The ratio of deaths from leukemia to deaths from cancer, the ratio of deaths from leukemia to total death rates, and death rates from leukemia were studied with the result that leukemia "was recognized approximately 1.7 times more frequently among physicians than among white males in the general population." The result is in accord with the increase in the incidence of leukemia in animals exposed to x-rays. Whatever the full meaning of the data at hand may be, the hazards of radiation require the strict maintenance of complete protection at all times.

News Notes

Formerly with the Army Medical Corps, Dr. Charles W. Comer, of Mooresville, has been given a discharge, and will resume his practice at Mooresville.

Dr. Mahlon F. Miller, of Fort Wayne, has been appointed a member of the Advisory Committee of the Bureau of Maternal and Child-Health, of the Indiana State Board of Health.

Dr. M. A. Austin, of Anderson, attended the annual reunion of his class at the University of Chicago, in June, and remained there the following week to attend the sessions of the American Medical Association.

Members of the Carroll County Medical Society, together with their wives, were entertained at a picnic dinner and garden party, on June twenty-second, by members of the Carroll County Nightingale Club, a nurses' organization.

Dr. Claude D. Holmes has opened offices in Frankfort for the practice of his profession. Prior to his retirement he served more than twenty-seven years as an Army physician, and has seen service in the larger military hospitals in various parts of the world. At the time of his retirement Dr. Holmes held the rank of colonel.

Dr. John C. Brink will leave Gary soon to accept a residency in surgery at the Receiving Hospital in Detroit. Doctor Brink has been in practice with his father, Dr. C. C. Brink, since completing his internship at the Methodist Hospital, in Indianapolis, a year ago.

Dr. James S. Fitzpatrick, of Indianapolis, and Miss Frances Johnson, of Scottsburg, were married June seventeenth at the Methodist Church at Scottsburg. Dr. and Mrs. Fitzpatrick will reside in Indianapolis, where Dr. Fitzpatrick is an intern at the City Hospital.

Dr. L. E. Pennington, formerly of South Bend, has been appointed superintendent of the Madison State Hospital. Dr. Pennington succeeds the late Dr. James W. Milligan. Dr. Pennington returns to Indiana from the Milledgeville State Hospital, at Milledgeville, Georgia, where he also held the position of superintendent. Prior to that he had also served as assistant superintendent at the Logansport State Hospital for nine years.

MEETING OF SOUTHERN MEDICAL ASSOCIATION

The Southern Medical Association has again extended an invitation to the members of the Indiana State Medical Association to its meeting, to be held in St. Louis November 13-16. More detailed information concerning the program will be published in our October issue of *THE JOURNAL*.

The Ninth Assembly of the United States Chapter of the International College of Surgeons will be held at the Benjamin Franklin Hotel, in Philadelphia, on October 3, 4, and 5, 1944. The sessions will be devoted to War, Rehabilitation, and Civilian Surgery.

At the Annual Meeting of the American College of Chest Physicians, held at Chicago, June 10-12, 1944, Dr. J. V. Pace, of New Albany, was re-elected as the Governor of the College for a term of three years. Thirteen Indiana physicians attended the meeting.

The first annual meeting of the Association of American Physicians and Surgeons, Incorporated, will be held in Chicago, on August 23, 24, and 25.

*Coming to the
Annual Convention
?*

Make your reservation now

for October 3, 4 and 5

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The annual meeting of the American Board of Obstetrics and Gynecology was held at Pittsburgh, Pennsylvania, from June 7 to June 13, 1944, at which time ninety-three candidates were certified. A number of changes in board regulations and requirements were put into effect, designed to aid both civilian as well as candidates in the service. Among these is the waiver, temporarily, of our A.M.A. requirement for men in the Army or Navy, especially for those who proceeded directly or almost so from hospital service into Army or Navy service, upon a statement of intention to join promptly upon return to civilian practice. At this meeting the board also has accepted a period of nine months as an academic year in satisfying the requirement for certain years of training. This is only for the duration, and even men who are not eligible for military service but who are nevertheless in hospitals where the accelerated program is in effect have been allowed to submit this short-time period of training in lieu of our previous requirements.

Beginning with the next written examination, which is scheduled to be held the first Saturday afternoon in February, 1945, the board will limit the written examination to a maximum period of three hours, and in submitting case records at this time all candidates' case abstracts whose obstetrical reports do not include measurements either by calipers and, as indicated, by acceptable x-ray pelvimetry, will be considered incomplete.

Prospective applicants or candidates in military service are urged to obtain, from the Office of the Secretary, a copy of the "Record of Professional Assignments for Prospective Applicants for Certification by Specialty Boards," which will be supplied upon request. This record was compiled by the Advisory Board for Medical Specialties and is approved by the Offices of the Surgeons-General, having been recommended to the Services in a circular letter, No. 76, from the War Department Army Service Forces, and referred to as the "Medical Officer's Service Record." These will enable prospective applicants and candidates to keep an accurate record of work done while in military service, and should be submitted with the candidate's application so that the Credentials Committee may have this information available in reviewing the application.

Applications and bulletins of detailed information regarding the Board requirements will be sent upon request to the Secretary's Office, 1015 Highland Building, Pittsburgh 6, Pennsylvania. Applications must be in the Office of the Secretary by November 15, 1944, ninety days in advance of the examination date.

INDIANA UNIVERSITY NEWS NOTES

War-time difficulties have been declared by Dean W. D. Gatch of the Indiana University School of Medicine in a report to the University's board of trustees to have resulted in definite benefits to the Indiana University Medical Center. Pointing out that the medical center since Pearl Harbor has suffered "calamity after calamity," Dr. Gatch asserted that this division of the University has "thrived on adversity" and now has enrolled 313 medical students, 300 nurses, 14 laboratory technicians and 21 dietitians.

The beneficial effects arising from the war were listed by the medical school dean as including higher scholastic achievements by students, critical review of the school's curriculum with consequent improvement in teaching, increased devotion of faculty, strengthened friendship with the physicians of the state, and closer cooperation with the Indianapolis City Hospital.

"Military discipline has been good for our students," Dr. Gatch advised the university's governing board with reference to the existing military status of all physically-qualified men medical students. "It has taught them to respect authority, to be punctual, and has made them work. A student who fails at the end of a semester is not allowed to repeat the work of that semester but must leave school at once. We have had few failures except in the freshman year."

Two changes affecting the medical school curriculum were reported by Dean Gatch. One he described as "the cutting away of obsolete and worthless material" and the reduction of the amount of work given in the specialties to that which a general practitioner needs to know. The other is institution of an arrangement whereby each senior spends one semester as a resident clerk in the university hospitals or at the Indianapolis City Hospital.

"The medical curriculum has grown through the years by a process of accretion to meet the demands of the various specialties," he said in his report. "Medical educators have for years recognized the bad effects of this process but have been unable to do much to remedy it. They recognized that we were cramming our students with information, but not educating them in the sense of making them self-reliant and capable of independent thought and judgment. Our curriculum committee has made a study of the entire curriculum. We have cut down the amount of work given in the specialties to that which a general practitioner needs to know. We have brought our students, as much as is possible, into direct contact with the patient, and have made them responsible for their own education. I believe this is sound pedagogy. We are trying to teach our students to practice medicine as a learned profession and not

(Continued on page xxiii)

(Continued from page 426)

as a trade, to make them skillful in all the techniques of diagnosis, prognosis and treatment, and to teach them to educate themselves."

The resident clerkship procedure for senior students, tried out last year, became effective in May, Dr. Gatch reported, adding that the emergency character of cases handled by the City Hospital will provide the students with clinical material not available at the university hospitals.

Development at the medical center of a full-time staff of clinicians, it was asserted by Dr. Gatch, has given the medical center men who "compare favorably with similar men in any school in the country. Each has a minimum of thirteen years of college, medical school, and post-graduate study."

Dean Gatch advised the university trustees that the medical center, looking to the period after the war, "has ready tentative plans for buildings, for improvements in teaching, for rendering better service to the state, for meeting probable calamities, et cetera." The plans, he added, also include the establishment, in association with the Indiana State Board of Health, of a school of public health, creation of extension courses of graduate medical instruction for hospital staffs, and continuation of research with "plenty of problems for future study."

Forty-seven students of the Indiana University School of Medicine were on the university's honor roll for the second semester of the past school year. Four of these students ranked in the highest one per cent of their respective classes, and the other forty-three in the next highest nine per cent. Those in the highest one per cent were Anne S. Nichols, Greencastle; John M. Miller, Indianapolis; Melvin A. Block, Evansville, and U. John Collignon, Richmond.

The following medical students were in the next highest nine per cent: Robert K. Allen, Akron, Ohio; George H. Belshaw, Bloomington; James O. Futterknecht, Mishawaka; Charles Eugene Jackson, Bluffton; William G. McDonald, Kirklín; Esther McGinness, Evansville; Louis J. Makielski, Mishawaka; George W. Mellinger, Indianapolis; Siegfried Schuldenfrei, Irvington, New Jersey; John A. Shively, Muncie; Charles F. Smith, Kokomo; Maurice A. Turner, Bloomington; Arthur M. Antonow, Terre Haute; Dan W. Everett, Indianapolis; Arthur K. Hamp, Kokomo; Paul D. Johnson, Jr., Terre Haute; Melvin Matlin, Brooklyn, New York; Robert L. Raphael, Evansville; William C. Robertson, Indianapolis; Donald M. Schlegel, Brazil; Eugene E. Schmidt, Huntington; George D. Buckner, Evansville; Joseph E. Coleman, Indianapolis; Louis H. Conn, Danville; John P. Graf, Indianapolis; Morris Green, Indianapolis; Omar A. Kenyon, Fort Wayne; Clarence Y. Knowles, Indianapolis; John E. Mackey, Evansville; Robert E. Moses, Worthington; Don A. Sears, Odon; Margaret M. Davis, Indianapolis; J. Patrick Duffy, Terre Haute; James S. Fitzpatrick, Bloomfield; Edwin E. Gregg, Indianapolis; Preston S. Houk, Portland; David M. Jones, Wilmore; Robert F. Kimbrough, Logansport; Robert O. Lancet, Indianapolis; Frederick O. Mackel, Clinton; John J. Reinhard, Jr., Washington, D.C.; Arnold R. Sanders, New York City, and Ben J. Wilson, Bloomington.

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MEDICINE—Two Weeks Course in Internal Medicine starts October 16.

GYNECOLOGY—Two Weeks Intensive Course starts October 2. One Week Course Vaginal Approach to Pelvic Surgery starts October 23rd.

OBSTETRICS—Two Weeks Intensive Course starts October 16.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

GASTROSCOPY—Personal Course starts October 16.

OTOLARYNGOLOGY—Two Weeks Intensive Course starts October 2.

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Society Reports

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

CASS COUNTY MEDICAL SOCIETY:

President, D. E. Lybrook, Young America.
Vice-president, C. T. Dutchess, Galveston.
Secretary-treasurer, H. M. Shultz, Logansport.

FAYETTE-FRANKLIN COUNTY MEDICAL SOCIETY:

President, H. W. Smelser, Connorsville.
Secretary-treasurer, R. H. Elliott, Connorsville.

CLARK COUNTY MEDICAL SOCIETY:

President, Ralph W. Bruner, Jeffersonville.
Vice-president, David G. Pryor, Jeffersonville.
Secretary-treasurer, J. T. Carney, Jeffersonville.

Fayette-Franklin County Medical Society members held a dinner meeting at Valley View, Brookville, on June sixth. Sixteen members and several guests were present.

Grant County Medical Society members held a meeting at Marion on July thirteenth. The meeting was devoted to a discussion of current business. The eleven members present agreed to cooperate in the mass x-ray program.

Howard County Medical Society members met at the St. Joseph Memorial Hospital, Kokomo, June ninth. This was a special meeting in honor of Lieutenant Commander Jesse S. Spangler, of Kokomo, who has been home on leave. Commander Spangler told of his experiences as a Navy doctor. Twenty-three members attended the meeting.

Montgomery County Medical Society members met at the Culver Hospital, in Crawfordsville, on June fifteenth. The speaker was Dr. L. Y. Mazzini, of the Indiana State Board of Health, who presented "Serodiagnosis of Syphilis." Thirteen members and guests were present.

Pike County Medical Society members held a dinner meeting on June second at the Winslow Christian Church, in Winslow. Dr. Jack B. Miller was the speaker for this meeting. He discussed "Penicillin." Thirteen members and guests were present.

Tippecanoe County Medical Society members met at the Lincoln Lodge, in Lafayette, on June thirteenth. Dr. C. K. Hepburn, of Indianapolis, presented "Problems of Neurosis in Military Service," following which a discussion was held by the members present. Twenty-eight members attended the meeting.

Wabash County Medical Society members held a meeting at the Women's Club, in Wabash, on June seventh. The society approved the x-ray filming of tuberculous subjects, as proposed by the County Tuberculosis Association. Thirteen members were in attendance.

Wayne-Union County Medical Society members held a dinner meeting at the Winnefeld Hotel, in Liberty, on June twenty-second. The doctors entertained their wives as guests at the meeting. The speaker was Dr. Mark Millikin, of Hamilton, Ohio. Thirty-two members and guests were present. (Nineteen members of this society are now serving in the armed forces of the United States.)

Books

BOOKS RECEIVED

PSYCHOANALYSIS TODAY. Edited by Sandor Lorand, M.D. 404 pages. Cloth. Price \$6.00. International University Press, 1944.

NOTES ON NURSING BY A NURSE. By Sarah Corry, R.N. 144 pages with several illustrations. Cloth. Price \$1.50. D. Appleton-Century Company, Incorporated, New York, 1944.

MAN DOES NOT STAND ALONE. By A. Cressy Morrison. 107 pages. Cloth. Price \$1.25. Fleming H. Revell Company, New York, 1944.

MINOR SURGERY. Edited by Humphry Rolleston and Alan Moncrieff. 174 pages with 30 illustrations. Fabrikoid. Price \$5.00. Philosophical Library, New York, 1944.

METASTASES, MEDICAL AND SURGICAL. By Malford W. Thewlis, M.D. 230 pages with 13 illustrations. Cloth. Price \$5.00. Charlotte Medical Press, Charlotte, North Carolina, 1944.

THE TREATMENT OF PEPTIC ULCER. By George J. Heuer, M.D., professor of Surgery of Cornell University Medical College. 118 pages. Fabrikoid. Price \$3.00. J. B. Lippincott Company, Philadelphia, 1944.

LIPPINCOTT'S QUICK REFERENCE BOOK FOR MEDICINE AND SURGERY. Twelfth edition. A Clinical, Diagnostic, and Therapeutic Digest of General Medicine, Surgery, and the Specialties, Compiled Systematically from Modern Literature. By George E. Rehberger, M.D. 1460 pages. Fabrikoid. Price \$15.00. J. B. Lippincott Company, 1944.

CLINICAL DIAGNOSIS BY LABORATORY EXAMINATION. First edition, revised. By John A. Kolmer, M.D., professor of Medicine in the School of Medicine and the School of Dentistry of Temple University, director of the Research Institute of Cutaneous Medicine. 1239 pages with 75 illustrations. Fabrikoid. Price \$10.00. D. Appleton-Century Company, Incorporated, New York, 1944.

THE ANALYSIS AND INTERPRETATION OF SYMPTOMS. Edited by Cyril M. MacBryde, M.D. 301 pages with several illustrations. Fabrikoid. J. B. Lippincott Company, Philadelphia, 1944.

INFANTS WITHOUT FAMILIES. The Case For and Against Residential Nurseries. By Anna Freud and Dorothy Burlingham. 128 pages. Price \$2.00. Cloth. International University Press, 1944.

THE INTERNATIONAL BULLETIN—Rosenow Poliomyelitis—Vol. A44. The Relation of Neurotropic Streptococci to Epidemic and Experimental Poliomyelitis and Poliomyelitis Virus, Diagnostic Serologic Tests and Serum Treatment. By Edward C. Rosenow, M.D., Professor of Experimental Bacteriology, University of Minnesota, Mayo Foundation, Rochester, Minnesota. 87 pages with 25 illustrations. The International Bulletin, 319 West 103rd Street, New York, Volume A44.

THE PRINCIPLES AND PRACTICE OF MEDICINE. Fifteenth edition. By Henry A. Christian, M.D., Hersey Professor of the Theory and Practice of Physic, Emeritus, Harvard University; clinical professor of Medicine, Tufts College Medical School. (This book was originally written by Sir William Osler, Bart., M.D., and was designed for the use of practitioners and students of medicine.) 1498 pages. Cloth. Price \$9.50. D. Appleton-Century Company, Incorporated, New York, 1944.

BOOKS REVIEWED

A.M.A. COUNCIL ON PHARMACY AND CHEMISTRY REPORTS FOR 1943. Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association, for 1943. Cloth. Price, postpaid, \$1.00. Pp. 150. Chicago: American Medical Association, 1944.

The present volume of reprints contains only eight reports on rejected articles; it is interesting to note that objections to these are on a much higher plane than those it was necessary to urge against the flagrantly quackish preparations of earlier days.

Perhaps the most noteworthy of the nineteen general and "status" reports in this volume is the one declaring the Council's intention of using henceforth only the metric or centimeter-gram-second system in its publications. The report itself gives some interesting and readable history on the subject of weights and measures. Of most timely interest to the general physician as well as the endocrine specialist is the report on nomenclature of endocrine preparations. The report gives a currently quite complete list of the available commercial preparations, including those not accepted by the Council as well as those which stand accepted. Another report in the field of endocrinology is that recognizing the use of estrogens in the treatment of prostatic carcinoma.

Attention should be called to at least two of the reports concerned with vitamin preparations, namely, the status report giving the Council's decision that the evidence does not yet warrant the acceptance of cod liver oil preparations for external use, and the report announcing the Council's recognition of the use of massive doses of vitamin D in arthritis, and this volume includes a

current comment from *The Journal of the American Medical Association*, titled "Hope (false) for the Victims of Arthritis," which re-emphasizes this objection.

The status report on xanthine compounds gives a much needed delimitation of the therapeutic claims that may be recognized for aminophylline and its related xanthine derivatives. Of similar interest is the report on the local use of sulfonamides in dermatology, and in the same category may be mentioned the report on agents for the treatment of *Trichomonas Vaginitis*, which points out that the present aim should not be for new medicaments in this field but for further information, especially concerning failures with those that have been used. In another status report the Council sets forth its conclusion that present evidence does not justify claims for advantage of oral use of sodium sulfonamides over the free drug.

In line with its decision to consider for acceptance various contraceptive preparations, the Council published a status report on conception control, which is concluded in this volume. The report comprises a series of concise statements on the various preparations and methods of control, prepared by Dr. Robert Latou Dickinson, together with a statement of criteria by which the Council will consider the acceptability of contraceptive jellies, creams, and syringe applicators and nozzles, diaphragms and caps.

It cannot be too often said that this volume, as well as the other publications of the Council, remains of paramount interest to all who are concerned with rational use of therapeutic agents.

NEW AND NONOFFICIAL REMEDIES, 1944. Contains descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1944. Cloth. Price, postpaid, \$1.50. Pp. 778. Chicago: American Medical Association, 1944.

The current volume of *New and Nonofficial Remedies* reflects two important and forward-looking decisions of the Council, namely, to use the metric system exclusively in all its publications, and to consider for acceptance contraceptive preparations offered for use as prescribed by physicians. These decisions in turn reflect the vigorous and progressive leadership of the Council in the service of medicine.

The chapter on contraceptives is quite comprehensive; with the acceptance of more preparations, it will undoubtedly assume a large place in *New and Nonofficial Remedies*. The Council has thus far accepted some contraceptive jellies and creams, contraceptive diaphragms, diaphragm inserts, syringe applicators, and fitting rings. It is understood that a number of additional preparations have been submitted for Council consideration since the book went to press. This chapter represents a courageous and long-needed innovation.

Some of the new preparations that appear in this volume are: Succinylsulfathiazole, a new sulfonamide, a proprietary brand being "Sulfasuxidine"; Diodrast Concentrated Solution, a preparation of the already accepted Diodrast, for use in a special diagnostic procedure for visualization of the circulatory system and also cholangiography; a preparation of Sodium Benzoate for use as a liver function test; Mersalyl and Theophylline, accepted under the name Salyrgan-Theophylline



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A glance at the preface shows that certain general articles have been revised to bring them up to date. More or less important revisions have been made of the following chapters: Barbituric Acid Derivatives, Estrogenic Substances; Parathyroid; Ovaries; Sulfonamide Compounds; Vitamins, especially the sections, Vitamin B Complex and Vitamin D. In this connection it is worth noting that each chapter in the book is reviewed annually, or more often if indicated, by the responsible referee for such revision.

This volume is of paramount interest to all those concerned with rational and modern drug therapy.

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—May, 1944

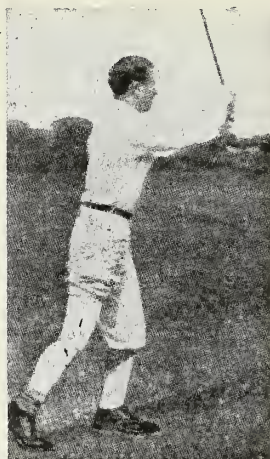
Diseases	May 1944	April 1944	March 1944	May 1943	May 1942
Tuberculosis, Pulmonary	137	255	146	328	170
Tuberculosis, Other Forms	3	3	0	97	28
Chickenpox	371	592	661	370	363
Measles	576	1185	1103	2248	875
Scarlet Fever	561	972	848	302	299
Smallpox	8	2	3	7	3
Typhoid Fever	9	6	16	8	7
Whooping Cough	46	49	67	320	281
Diphtheria	17	23	33	23	11
Influenza	6	24	52	39	20
Pneumonia	5	27	40	70	47
Mumps	208	268	238	483	195
Poliomyelitis	1	1	1	1	0
Cerebrospinal Meningitis	23	38	37	34	3
Nonepidemic Meningitis	1	1	0	0	0
Rubella	10	29	14	320	156
Trachoma	1	0	0	0	0
Vincent's Angina	1	4	2	0	2
Undulant Fever	3	6	5	8	1
Conjunctivitis	1	2	0	0	0
Impetigo	2	0	2	0	0
Dysentery	1	27	0	0	0
Tetanus	1	0	0	0	0
Septic Sore Throat	1	25	23	2	1

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—June, 1944

Diseases	June 1944	May 1944	April 1944	June 1943	June 1942
Tuberculosis, Pulmonary	519	137	255	235	111
Tuberculosis, Other Forms	2	3	3	29	11
Chickenpox	182	371	592	150	132
Measles	275	576	1185	1133	305
Scarlet Fever	192	561	972	131	96
Typhoid Fever	3	9	6	9	7
Whooping Cough	74	46	49	248	168
Diphtheria	13	17	23	13	9
Influenza	4	6	24	6	14
Pneumonia	4	5	27	25	25
Mumps	199	208	268	110	59
Poliomyelitis	1	1	1	1	0
Cerebrospinal Meningitis	18	23	38	23	1
Trachoma	1	1	0	0	0
Undulant Fever	10	3	6	6	2
Rubella	12	10	29	65	19
Dysentery	1	1	27	0	0
Malaria	3	0	4	1	2
Vincent's Angina	1	1	4	0	6



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ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

SEPTEMBER, 1944

NUMBER 9



A STUDY OF UPPER RESPIRATORY INFECTIONS

LIEUTENANT COLONEL FRED E. BALL, M.C.

LIEUTENANT COURTLANDT D. BERRY, M.C.

AAF Regional Station Hospital
KEARNS, UTAH

Because of the necessity of frequent hospitalization for soldiers with nasopharyngitis, tonsillitis, and other upper respiratory infections, it was decided to study this group of diseases clinically and, to a lesser degree, bacteriologically. Considerable confusion^{1,2,3,4,5,6} has existed as to the value of sulfadiazine in these conditions, and such a study would present a fine opportunity to get more information. In an effort to obtain a clearer understanding of the primary diseases, only uncomplicated cases were studied. Patients with admission complications of sinusitis, pneumonia, otitis media, laryngitis, scarlet fever, bronchitis, adenitis, peritonsillar abscess, conjunctivitis and Vincent's infection were not accepted for this program.

"Clearing" or "screening" wards were set up, and all patients with respiratory diseases were sent to these wards for throat cultures, observation, and

diagnosis. After a twenty-four-hour period, uncomplicated cases of upper respiratory infections, including tonsillitis, were transferred to one of two wards, depending on the presence or absence of significant numbers of hemolytic streptococci in their throat cultures. The bacteriological work was done by Lieutenant Charles G. Jennings. During the first third of the experiment the cultures were inoculated in the laboratory onto human blood plates from throat swabs taken on the "screening" wards. During the latter two-thirds of the experiment throat swabs were taken in the admitting office and were inoculated immediately onto sheep's blood plates. The swabs were streaked on the surface of the plates, and they were incubated from eighteen to twenty-four hours aerobically at 37°C. The throat cultures were graded on the basis of 0 to 4+. A culture graded "0" showed a complete absence of hemolytic colonies. A culture graded "1+" showed no more than five hemolytic colonies in the streaked-out portion of a well-inoculated plate. A culture graded "2+" showed more than five and less than twenty-five hemolytic colonies. A culture graded "3+" showed more than twenty-five hemolytic colonies, and a culture graded "4+" was a pure, or practically pure, culture of hemolytic streptococci. Subsequent examination of the hemolytic colonies revealed 98 per cent of these were streptococci belonging to Lancefield Group A.

¹ Cecil, Russell, et al.: *J. Am. Med. Assoc.*, **124**:914 (Jan. 1) 1944.

² Davis, Harry J.: *J. Ind. Med.*, **12**:426, (July) 1943.

³ Dolowitz, David A., et al.: *J. Am. Med. Assoc.*, **123**:334, (Oct. 30) 1943.

⁴ Lieutenant Colonel Howard A. Rusk and Major Arie C. Van Ravenswaay, *J. Am. Med. Assoc.*, **122**:495, (June) 1943.

⁵ Gettelman, Eugene: *Navy Medical Bull.*, **XLII** No. 2, (Feb) 1944.

⁶ Gregory, Kalei: *Rhode Island Med. J.*, **27**:111-112, 120, (March) 1944, quoted in *Med. J. Abstract*, **Vol. F.**, (April) 1944.

TABLE I
CLINICAL CHARACTERISTICS AND COMPLICATIONS

	GROUP I No Hemolytic Bacteria, No Sulfa.	GROUP II No Hemolytic Bacteria, and Sulfa.	GROUP III Hemolytic Strep., and No Sulfa.	GROUP IV Hemolytic Strep. and Sulfa.
Patients discharged in two months (Jan. 7 to March 7).....	114	99	84	91
Average length of stay in hospital.....	7.2	5.8	8.4	6
Longest stay in hospital.....	31	12	22	13
Average of admission temperatures.....	100.5°	100.°	100.1°	100.°
Average of highest temperatures.....	101.1°	101.2°	100.6°	101.5°
Bacterial Complications*.....	13	1	34	1
Tonsils present and inflamed.....	57%	60%	60%	70%
Sulfadiazine Complications**.....	0	2	0	1
* GROUP I GROUP II GROUP III GROUP IV				
Sinusitis .....5	Adenitis .....1	Bronchopneumonia 5	Adenitis .....1	
Bronchitis .....1		Sinusitis 8		
Laryngitis .....1		Scarlet Fever .....1		
Bronchopneumonia .....3		Conjunctivitis .....3		
Adenitis .....1		Peritonsillar Abscess .....6		
Vincent's Infection .....2		Laryngitis .....2		
		Adenitis .....6		
		Otitis Media .....1		
		Bronchitis .....1		
		Vincent's Infection .....1		
** GROUP II GROUP IV				
Severe Vomiting .....1	Skin rash and fever.....1			
Urticarial Reaction .....1				

The patient with no hemolytic streptococci in their throat cultures, or with a "1+" culture, were considered as not having a significant number of hemolytic streptococci in their throats, and they were placed on one ward. The remaining patients with throat cultures graded "2+," "3+," or "4+" were placed on another ward. Alternate admissions to each ward received a specified dose of sulfadiazine, in addition to the routine symptomatic treatment. This dosage consisted of an initial 2 gms., which was repeated in two hours. Two hours later 1 gm. was given and this was followed by 1 gm. every four hours day and night. Sulfadiazine blood levels were taken between twenty-four and thirty-six hours after the sulfadiazine was started.

The period of hospitalization, the complications developing after admission, the sulfadiazine total dosage, and the sulfa blood levels were tabulated for each of the four groups created. The clinical and bacteriological relationships were studied in each of the groups. No readmissions within one week from the time of discharge were found in the first month's study, so the readmission rate was deemed too low to be determined for the entire period. An attempt was made to show the relationship between the onset of the illness, prior to admission, and the hospitalization required after admission. The program was in effect for two months, and its execution was not found particularly difficult. The summarized data is found in TABLES I, II, III, IV, V, VI, and VII.

A sufficiently large number of cases (388) was studied to obtain a reasonable sample of the type of respiratory infection occurring at the time of the study, which ran from January 7 through March 7. The climate was moderately cold and the location was in the intermountain area of the West.

TABLE I indicates that sulfadiazine reduces the length of hospitalization both in the hemolytic

streptococcus and the non-hemolytic bacterial infections. The longest individual periods of hospitalization were found in patients not receiving sulfadiazine. Temperature elevations in all groups were largely similar, but complications occurred far more frequently in the two groups not receiving sulfadiazine. The presence or absence of tonsils did not appear to have any bearing on the bacteriological findings. When sulfadiazine was administered, complications were at a minimum.

TABLE II suggests that the disease was generally of moderate severity regardless of the bacteriology in the throat cultures. Nevertheless, almost 80 per cent of the cases of severe infection had hemolytic streptococci in their throat cultures.

TABLE II
THE INITIAL CLINICAL SEVERITY OF THE DISEASE

Group	Mild	Moderate	Severe
I	36	74	5
II	16	59	13
III	11	51	26
IV	6	49	36

TABLE III shows the relative number of hemolytic streptococci in the throat cultures of groups III and IV. Approximately 85 per cent of the cases had 3 or 4+ throat cultures.

TABLE III
RELATIVE NUMBER OF HEMOLYTIC STREPTOCOCCI
PRESENT IN THROAT

Group	2+	3+	4+
III	12	47	25
IV	12	45	34

TABLE IV illustrates the sulfadiazine blood levels obtained between twenty-four and thirty-six hours after the drug was started. The total dosage is also indicated.

TABLE IV
THE SULFADIAZINE BLOOD LEVELS AND TOTAL AMOUNT
ADMINISTERED WITH THE STANDARD DOSAGE

	BLOOD LEVEL Mgms/100 cc.			TOTAL DOSAGE Grams		
	High	Average	Low	High	Average	Low
Group II:	13	8	3	41	20	8
Group IV:	17	8	4	54	26	3

TABLE V includes only cases which did not develop complications while in the hospital. It illustrates the fact that regardless of the bacteriology in the throat cultures, and regardless of the length of time the illness existed prior to treatment, when patients do not get well spontaneously and must eventually be hospitalized, the period of hospitalization required is approximately uniform.

TABLE V
UNCOMPLICATED RESPIRATORY INFECTIONS
GROUP I—(101) Cases—No Strep. No Sulfa.)

Total length of illness (in days) prior to hospitalization.....	1	2	3	4	7
Average length of stay in hospital (in days).....	6	6	6	6	6

GROUP II—(98) Cases—No Strep. and Sulfa.)									
Total length of illness (in days) prior to sulfadiazine therapy.....	1	2	3	4	5	6	7	8	10
Average length of stay in hospital (in days).....	4	6	6	6	7	6	5	4	6

GROUP III—(50) Cases—Strep. and No Sulfa.)							
Total length of illness (in days) prior to hospitalization.....	1	2	3	4	5	6	7
Average length of stay in hospital (in days).....	6	6	7	6	7	6	6

GROUP IV—(90) Cases—Strep. and Sulfa.)									
Total length of illness (in days) prior to sulfadiazine therapy.....	1	2	3	4	5	6	7	8	15
Average length of stay in hospital (in days).....	7	6	7	5	6	8	7	6	4

TABLE VI indicates the relationship between the clinical severity of the disease and the relative number of hemolytic streptococci in the throat cultures. It demonstrates that individual cases, regardless of the clinical severity, have none to "4+" hemolytic streptococci in their throat cultures. The majority of the severe cases, however, have large numbers of hemolytic streptococci in their throat cultures.

TABLE VI
INITIAL CLINICAL SEVERITY AND RELATIVE NUMBERS OF
HEMOLYTIC ORGANISMS

	Mild (69 Cases)	Moderate (283 Cases)	Severe (80 Cases)
0	48 (70%)	121 (52%)	20 (25%)
1+	5 (7%)	13 (5%)	3 (4%)
2+	4 (6%)	14 (6%)	3 (4%)
3+	6 (8%)	60 (26%)	26 (32%)
4+	6 (8%)	25 (11%)	28 (35%)

TABLE VII demonstrates that complications occur in the "nonsulfa" groups regardless of the bacteriological findings in the throat cultures. However, the majority of the complications in these groups developed in the cases with "3+" and "4+" hemolytic streptococci in their throat cultures.

TABLE VIII reemphasizes the fact that patients developing complications after admission have a longer average period of hospitalization than those who do not develop complications.

TABLE VIII
RESPIRATORY INFECTIONS WITH COMPLICATIONS
DEVELOPING IN THE HOSPITAL

GROUP I.	13 Cases—No strep. and no sulfa. Average length of stay 14 days.
GROUP II.	1 Case —No strep. and sulfa. Stay 5 days.
GROUP III.	34 Cases—Strep. and no sulfa. Average length of stay 12 days.
GROUP IV.	1 Case —Strep. and sulfa. Stay 6 days.

- Conclusions:
- (1) The efficacy of sulfadiazine in upper respiratory infections, including tonsillitis, seems to lie in its ability to prevent complications. The period of hospitalization, regardless of the type of therapy, is similar in the patients who do not develop complications.
- (2) It is not possible to differentiate with assurance, clinically, hemolytic streptococcus or non-hemolytic bacterial upper respiratory infections, but the majority of cases of severe tonsillitis, of severe upper respiratory disease, have hemolytic streptococci in their throat cultures.
- (3) Sulfadiazine in reasonably large doses did not cause any significant reactions in 190 cases of upper respiratory disease.
- (4) The use of a "screening" ward, for a period of twenty-four hours, aids in the proper segregation of patients, when routine throat cultures are made on entrance of all cases of upper respiratory infections.

TABLE VII
LENGTH OF HOSPITAL STAY AND COMPLICATIONS AND RELATIVE NUMBER OF ORGANISMS

	NO SULFA			SULFA		
	Total Number	Length of Stay	Complications	Total Number	Length of Stay	Complications
0 - +1	114	7.2	13 (11%)	99	5.8	1 (1%)
2+	12	8.5	3 (25%)	12	6.2	0
3+	47	8.8	22 (47%)	45	6.0	1 (2%)
4+	25	7.2	9 (36%)	34	5.9	0

THE COMBAT FLIGHT SURGEON IN ENGLAND

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This paper presents a general picture of the duties and combat problems of the flight surgeon in England from the beginning of heavy bombardment operations in the fall of 1942 to April, 1944. Observations were made of Flying Fortress (B-17) crews only, and consequently the specific aviation medical problems of the fighter, medium bombardment, and other groups are not included.

Flight surgeons are medical officers highly trained in the facts and fundamentals of aviation medicine, and have field experience with flying personnel. Their primary duties consist of proper selection of flying personnel and subsequent maintenance of physical fitness of these selectees. Flight surgeons in combat zones everywhere are today utilizing their skill and ability in maintaining physical fitness in flying personnel. Their efforts play a large part in keeping planes in the air.

Each Air Force squadron has a squadron flight surgeon with the ultimate rank of captain. Similarly, each Air Force group, in addition to the squadron surgeons, has a group flight surgeon with the rank of major whose duties are to supervise, advise, and assist the squadron surgeons. Ideally, flight surgeons are assigned to units soon after their formation and thus play an active role in the early indoctrination and training of the unit. During this precombat training period the flight surgeon can become intimately acquainted with his flying personnel and can note emotional backgrounds and reactions, eccentricities, and individual thresholds to stress and strain.

The flight surgeon is both a highly trained specialist and a family doctor, competent to handle the physical as well as the mental ills of his personnel. When his unit goes into combat, the flight surgeon lives the air battle with each of the men he has carefully nursed through a rigorous precombat training period. Sooner or later combat airmen will turn to him for comfort, consolation, and relief.

GENERAL DUTIES

The flight surgeon is responsible for the health of his men and each day must consider and dispose of many problems only remotely related to medicine. To enhance close personal relationship, he lives with the combat flyers; eats with them; plays cards with them; has "bull sessions" with them; and goes on pass with them.

He must see that adequate amounts of nutritious food and comfortable living quarters, necessary to high morale, are provided. Whenever possible, combat crew messes are established for serving

special foods to combat crewmen and to assure them of hot, freshly-prepared meals before briefing and after return from a mission.

The flight surgeon takes part in the athletic and recreation program at his station and advises the Special Service officers in planning this important program.

Problems of sanitation are met by the flight surgeon. Fortunately, the problem of sanitation in the British Isles has not been serious.

THE FLIGHT SURGEON'S PART IN PLANNING AND EXECUTING COMBAT MISSIONS

Each day, after sick call, the flight surgeon reports the men "grounded," or removed from flying duty, to the squadron commander and the operations officer, who in turn removes the men's names from the "available for duty" list. He must exercise careful judgment when grounding or restoring men to flying duty, and his decisions may mean life or death for one to ten combat flyers.

When a combat mission is being planned by the Air Force Headquarters, the "alert" is given to the participating groups at any time between noon and midnight of the day preceding the mission. Upon receipt of the warning the flight surgeon makes general check of available men and makes last-minute decisions on grounding or removal from grounding. He must then play the part of the truant officer, rounding up his men and getting them to bed early. Most flyers are conscientious about getting sufficient rest preceding a mission and will cooperate intelligently.

Briefing, the hour or so when all vital information concerning the forthcoming mission is given to the men, is held a few hours before actual time of take-off. The men are aroused about an hour before briefing and either ride bicycles or walk to the mess hall for breakfast, which on these mornings frequently means fresh eggs, a rare treat in England. Every good flight surgeon gets up with his men, eats breakfast with them, and attends briefing with them. During this period the flight surgeon can learn a great deal about his men. By careful observation he notes their psychologic reactions, the state of their appetite, the number of cigarettes they smoke, and whether they look rested or tired, happy or depressed, anxious or reluctant.

Information given during briefing will be of some value to the flight surgeon. Frequently he can anticipate the number and severity of his casualties if he knows the length of the mission, the altitude and predicted temperature, the flight

position of his squadron, and the anticipated strength of the enemy's defense.

Following briefing the flight surgeon goes to the flight line for a final check on his men at take-off, paying particular attention to the adequacy of their flying clothing and oxygen equipment. When missions are long and time between meals is great, the flight surgeon usually supervises the feeding of a small lunch to the flyers.

The question has often been asked, "Do flight surgeons go on combat missions?" In the European Theater of Operations many flight surgeons have gone on combat missions, and some have had unusual and interesting experiences. Participation in combat missions is not mandatory and the decision lies entirely with the medical officer concerned. One psychiatrist with the Eighth Air Force decided to participate in five successive missions as scheduled, to evaluate the stress and strain experienced by the flyers. On the last mission of the series, the bomber in which he was riding returned to the home base forty-five minutes overdue, riddled by flak and cannon fire, and bearing several casualties. The oxygen system was badly damaged by enemy action, creating additional problems.

From the medical standpoint, little is gained from actual participation in a mission, although it may bring the flight surgeon closer to his men and create a common understanding of their reactions. Most combat flyers would rather see the medical officer stay at home, where he will be on the line to care for their wounded.

Medical enlisted personnel does not accompany heavy bombardment crews on combat missions. Their value as medical men would not compensate for the extra weight. Thus, all combat crewmen are trained in first aid, and detailed instruction is given to two members of each crew.

During a mission one ambulance manned by four medical enlisted men and one flight surgeon

is on the flight line at all times. This crew meets all aircraft that "abort" or return before completion of the mission. Their purpose is not only to care for casualties but to investigate the reason for aborting, if it is of a medical nature. This would include oxygen trouble and physical complaints of crew members.

One hour before the "ETA," or expected time of arrival of the airplanes, four or more ambulances, each manned by four medical enlisted men and one flight surgeon, are present on the flight line. Two of these ambulances proceed to the distal end of the runway on which the planes will land, and the others remain at the control tower in constant communication with flying control officers, usually by means of radios installed in the ambulances.

Aircraft bearing casualties are given priority in landing and indicate casualties aboard by firing red flares on approach. The flight surgeon enters the aircraft, evaluates the condition of the casualties, and carries out the necessary treatment in the aircraft or prepares the casualties for evacuation to the nearby base sick quarters. Not infrequently emergency measures to combat shock and arrest hemorrhage are carried out in the aircraft. Removing seriously wounded men from the cockpit or nose of heavy bombardment aircraft is a difficult maneuver.

"Station Sick Quarters" are actually small emergency hospitals, quite adequate and well equipped. They are usually a connected series of large Nissen huts, frequently centrally heated, equipped with hot and cold running water, bath tubs, and electricity. Treatment of casualties in sick quarters consists of all measures to save life and prepare the patients for evacuation to a United States Military Hospital. Consultants and surgical teams are available on call from nearby United States Military Hospitals, and occasionally patients with



FIGURE I

*British ambulance being
used to transport a patient
from a squadron
dispensary.*



FIGURE II

*Removing a casualty
through the waist gun
window of a B-17.*

complicated and serious illnesses undergo definitive surgery at the sick quarters. Usually casualties are in favorable condition for evacuation within a few hours after removal from the aircraft.

We are fortunate in England in having numerous well-equipped and well-staffed United States Military Hospitals close to our operational bases. All required definitive treatment is carried out in these station and general hospitals.

Just prior to the interrogation, coffee and sandwiches are served to combat airmen who have participated in that particular mission. Whenever the flight surgeon is not occupied in treating casualties, he attends the interrogation immediately following the mission. He has the opportunity to check his men for mild frostbite or aerotitis media, to observe their psychologic reactions to the mission, to receive reports of unsatisfactory personal equipment, and again to prove his interest in the welfare of his men.

TYPES OF CASUALTIES

Less than one per cent of all heavy bombardment combat crewmen returning from missions are wounded or killed in action. This is a surprisingly low figure in a combat zone where enemy defensive measures are heavy.

Battle casualties result from four main types of missiles: anti-aircraft or "flak"; cannon; machine gun; and flying parts of the aircraft. Flak and cannon cause the highest percentage of wounds. Since many of the wounds are caused by low velocity projectiles (flak), they are usually shallow, penetrating, or lacerating types of wounds. Fractures are infrequent.

More than two-thirds of all wounds are slight, the others moderate or severe. Areas of body affected in order of frequency are extremities, head and neck, thorax, and abdomen. The majority of the fatal wounds are of the head, neck, and thorax.

The use of body armor, known commonly as the "flak suit," has protected many men from wounds and has lessened the severity of wounds and saved lives in a great many instances. The slight inconvenience of the added weight is insignificant in view of its life-saving properties.

PROBLEMS PECULIAR TO HIGH ALTITUDE COMBAT OPERATIONS

Frostbite or Cold Injury, High Altitude Type.—Frostbite is a major problem. On occasion extremely low temperatures accounted for more casualties than the Luftwaffe and enemy anti-aircraft fire. Temperatures of -55°C are occasionally encountered at high altitudes over the British Isles and Europe. In addition, waist-gunners are exposed to high velocity windblasts which increase the incidence of frostbite tremendously, especially of the face.

The term "frostbite" is a misnomer, since to the average layman it infers a mild degree of frosting or cold injury. Cold injury, high altitude type, is more appropriate. Exposure to extremely low temperatures for relatively short periods of time are sufficient to produce pathological changes, varying from slight blanching of the affected part, with rapid recovery, to the extreme of gangrene with loss of the part. Fortunately, the majority of cases are mild and recovery is usually rapid. Most cases necessitate grounding the patient for only a few days, but a small percentage is permanently lost to combat flying.

Flight surgeons and, later, personal equipment officers have reduced significantly the incidence of cold injury. Crewmen are thoroughly instructed in the known preventive measures. Individual clothing, both electrically-heated and otherwise, has been modified and improved continually. Face and neck protectors were devised. Special drying and locker rooms for the care of clothing and personal equipment have been provided.

Respiratory Infections and Aero-Otitis Media.—Climate in the British Isles is characterized by a high degree of humidity and frequent precipitation. Many troops develop respiratory infections upon arrival in the United Kingdom. The incidence of aero-otitis media is high.

Aero-otitis media, as defined by Armstrong, is an acute or chronic traumatic inflammation of the middle ear, caused by a pressure difference between the air in the tympanic cavity and that of the surrounding atmosphere. It results from changes of altitude in flight when there is inadequate ventilation of the middle ear cavity.

Aero-otitis occurring in experienced flyers is usually the result of an inability to open the eustachian tubes. Eustachian tube stenosis results from upper respiratory infections, sinusitis, and tonsillitis. Repeated upper respiratory infections often result in hypertrophy of small areas of lymphoid tissue, encroaching on the torus tubarius.

Contrary to the accepted belief, the rate of aircraft ascent or descent has very little bearing on the incidence of aero-otitis. This has been shown by comparative rates between fighter and bomber aircraft personnel. It is believed that the higher the maximum altitude reached, the greater is the likelihood of incurring aero-otitis on descent.

The ratio of naso-pharyngitis to aero-otitis is about four to one. A lowering of the incidence of upper respiratory infections results in lowering the incidence of aero-otitis. Measures to reduce aero-otitis include prohibiting flying for five days after recovery from naso-pharyngitis; adequate instruction in proper middle-ear ventilation in flight; medical or surgical treatment for pathology of the nasopharynx; and immediate and repeated nasal decongestion when aero-otitis is suspected.

Aero-otitis necessitates grounding for a few days to several weeks, with the average about seven

days. A small percentage is permanently lost to combat flying.

Anoxic Anoxia.—High altitude missions for long periods necessitate the use of supplementary oxygen. Occasionally men experience oxygen difficulties because of either mechanical failure or personal error and carelessness.

In the first heavy bombers to be used on operational work, difficulty was experienced because of freezing of the oxygen masks (type A-8B) which were used with the constant-flow system. Since the advent of the "demand" oxygen system (sufficient amounts of oxygen automatically furnished for any given altitude) and the new types of oxygen masks (types A-10, A-10R and A-14), the problem of freezing of the mask has been minimized greatly.

Some difficulty has been experienced because of the type of connector used between the oxygen mask tubing and the tubing connecting to the oxygen regulator.

Partial or complete destruction of the oxygen system by enemy action accounted for a few of the anoxic incidents.

Many interesting and valuable observations have been made in relation to individual oxygen demands at various altitudes. Pathological studies from post-mortem specimens are being carried on at the present time and should produce valuable information.

The flight surgeon, in cooperation with the personal equipment officer, must instruct and indoctrinate flying personnel in the use of oxygen and oxygen discipline. This is done during precombat training as well as during operational flying, and refresher lectures are given monthly. Modifications and improvements in the oxygen system are being carried out at all times.

FIGURE III

Combat casualties are moved from the plane to the Station Sick Quarters.





FIGURE IV

Casualties requiring prolonged or definitive treatment are moved to United States Military Hospitals.

OPERATIONAL FATIGUE

"Operational Fatigue" or "Operational Exhaustion" are coined terms applied to combat flyers who become mentally and physically exhausted after a variable number of operational missions. It is an illness resulting from actual physical fatigue plus prolonged or severe mental tension.

Operational fatigue may appear after three to ten unusually "rough" or hazardous missions, but more frequently it appears after twelve or more missions. It affects a very small percentage of all combat flyers, and in the past more than 50 per cent of treated cases have been returned to operational flying. Predisposing causes include exposure to harrowing experiences; the loss of friends in one's own unit; excessive periods of operational flying without sufficient recreation and rest; and the loss of the desire to continue in combat. Any one of these causes might be well tolerated by the individual, but the combination of several gradually results in the picture of operational fatigue.

Symptoms for which the flight surgeon must watch and which he must evaluate are loss of appetite, insomnia, irritability, loss of weight, tremor, battle dreams, personality changes, and, perhaps most important of all, the loss of the desire to fly. Symptoms are usually cumulative and gradually increase in severity until the man must be removed from flying, both for his own welfare and for the welfare of his crew. Frequently the flyer recognizes the symptoms and presents himself to the flight surgeon for diagnosis and treatment. The flight surgeon conducts a thorough mental and physical examination of the patient, and then refers him to a board of con-

sultant psychiatrists for treatment and disposition.

Treatment consists essentially of amytal-induced narcosis for a period of forty-eight to ninety-six hours, usually not accompanied by psycho-suggestion. Following this the patient is sent to a rest home for one to two weeks of psychotherapy, then is either declared fit or unfit for further combat. The rest homes afford all opportunities for complete relaxation and physical conditioning. The small number of cases of operational exhaustion has been gratifying. It is extremely important to anticipate operational exhaustion in flying personnel and to get them away from operational stations on leaves whenever possible. In most cases a short leave will restore a flyer with "preclinical" exhaustion to a normal mental and physical state.

Generally, combat flyers are entitled to a forty-eight-hour pass every fourteen to eighteen days, and a six-day leave after completion of a given number of missions, usually half the number stipulated as a tour of operational duty. Sick leaves are granted upon the recommendation of the flight surgeon. When all-out efforts are called for and every able flyer is needed for combat, passes and leaves are cancelled and all efforts are directed toward getting as many airplanes as possible into combat. At the conclusion of these all-out efforts the men receive passes and leaves.

Very few combat flyers develop frank anxiety states in relation to combat flying. This may occur early in their combat careers, frequently following one or two missions. These cases are rarely amenable to any form of treatment and are permanently grounded and disposed of administratively.

VENEREAL DISEASE AND FLYING PERSONNEL

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The major objectives in control of venereal disease in flying personnel are the same as in all military personnel, namely, prevention of infection and reduction of the period of disability, or more accurately the time lost from duty. Circumstances peculiar to the Air Forces, and to the duties of flying personnel in particular, introduce factors and considerations which justify a somewhat different approach to the problem. Because of factors which will be discussed below, morbidity and time lost from duty in flying personnel are more costly in terms of organizational efficiency than is true for the same number of individuals in most other branches and arms of the service.

Features Peculiar to Army Air Forces

Because of the exacting nature of the duty, flying personnel have prolonged and detailed training which assumes great magnitude in terms of time, effort, money, and materials. It has been estimated that it costs approximately twenty-five thousand dollars to fully train a combat pilot, and amounts somewhat less for training other members of the air crew.

Probably the greatest loss in time of war is the loss in terms of availability of personnel upon whom depends what in modern warfare is a prime strategic and tactical segment of the Army. In the over-all picture of the Air Forces, the need for trained personnel can probably be considered the most crucial. The loss of such personnel in combat theatres and in training represents a loss which can least be compensated.

Flying personnel, with the exception of the fighter pilot, work essentially as teams, and the loss of a single man from the team often means that the entire crew is unavailable for duty until suitable replacement can be provided. Since such replacement is often difficult to obtain, it must constantly be kept in mind that the loss of a single man with venereal disease more often than not means that at least several other men will be temporarily off duty. This circumstance greatly magnifies the significance of every venereal disease infection which occurs in flying personnel.

The extreme physiologic stress which accompanies flying duty requires that the highest physical standards be maintained in the personnel; therefore, return to duty will be more delayed in flying personnel than in any others because time must be allowed for more complete recovery. In addition, drugs used in treatment of many diseases cause physiologic disturbances or potential reactions

which render the individual incapable of safely performing flying duty, whereas the same effects and reactions would not prevent ground duty. This, too, is an important factor in prolonging the period of grounding.

Since the total number of qualified flying personnel is relatively small, each individual becomes relatively more important; and as has been previously mentioned, training is slow and time-consuming, and the training of new personnel and the obtaining of replacements is not an easy problem.

Since physical standards are extremely high, and drug reactions may be the cause of accidents, concealed infection and treatment unknown to the military authority take on an added significance when flying personnel are involved. It becomes similarly important to make every effort to prevent such occurrences; and this involves consideration of numerous administrative, morale, and psychologic factors. Administrative and personnel practices and policies, such as loss of pay, failure to maintain confidential nature of the infection, regulations for grounding for varying conditions and treatment, disciplinary action (improperly applied), and others must be carefully weighed and judiciously applied.

The Medical Aspects of Flying Duty

As has been previously pointed out, the physical requirements for flying personnel must necessarily be high. Minor disturbances of function while in flight may result in accidents, the extreme cost of which need not be emphasized. Expressed in terms of physical and physiologic abilities, the qualities which the flyer must have are a high level of consciousness, alertness, orientation, judgment of time and distance, muscular coordination, short reaction time, visual efficiency, altitude tolerance, ability to withstand fatigue, et cetera. Any factor which adversely affects the above qualities impairs the ability of the individual to perform flying duty.

Disturbances Characteristic of Flight

Physiologic disturbances and pathologic conditions which have been established as characteristic of and peculiar to flight need not be discussed in detail. Briefly enumerated, they are aero-otitis media, effects on equilibrium and orientation, air sickness, anoxia, acute and chronic altitude sickness, mechanical effects of decreased atmospheric pressure, areo-embolism, and effects of speed and acceleration. These must be considered from the standpoint of how their occurrence may be in-

fluenced by the venereal diseases and the drugs used in treatment.

Venereal Diseases as Related to Flying Duty

Venereal diseases, themselves, must be considered from three standpoints as they effect the ability to perform flying duty, namely, the possible effects of the disease on normal physiology, the effects on the occurrence of disturbances characteristic of flight, and the possible accentuation of minor pathologic changes, ordinarily below the clinical horizon, under flying conditions.

Current Physical Standards as Defined in Army Regulations

Lymphogranuloma venereum and granuloma inguinale are disqualifying for any type of military service. This is based upon the fact that these diseases are chronic and no satisfactory treatment is available, and they would represent a medical burden even though in most instances they do not result in physical disability of any marked degree. When such infection is acquired after induction during flying training or after the individual is qualified for flying, they are, according to Army Regulations, a cause for discharge from the service. In practice, however, their disposition varies, depending upon their extent and early response to treatment, and depending upon whether they occur in individuals who have had long service and a high degree of training.

Ducrey infections, uncomplicated, are acceptable for general military service since the great majority of cases readily respond to sulfonamides and are cured within a few weeks. Such individuals are then perfectly able to carry on any type of military duty, including flying duty, if they are otherwise qualified. If such infection occurs in individuals undergoing flying training, or on active flying duty, they are grounded during the course of treatment because of the drugs which are used in treatment, as will be discussed later. It is only on rare occasions that the disease itself would produce changes which would make the individual physically incapable of performing flying duty.

Gonorrhea, uncomplicated, is also acceptable for general military service since it, too, can in most instances be cured in a few weeks with sulfonamides, after which the individual is physically qualified for any type of military duty. While under treatment the individual is temporarily disqualified for flying. The availability of penicillin reduces the period of disability from gonorrhea almost to the vanishing point, since a curative dose can be administered in less than twelve hours, and there are no drug reactions which prevent immediate return to flying duty. (See later discussion under sulfonamides.) Except for the rare complications of gonorrhea, such as arthritis, endocarditis, and others, the disease seldom produces disturbances which would physically disqualify.

The presence of syphilis of the central nervous system, cardio-vascular system, or viscera, and in

fact any clinically active syphilis—other than primary and secondary—is disqualifying for induction in the Army. Specifically, individuals with primary and secondary and latent syphilis, regardless of the amount of treatment, are qualified for induction; however, they are not qualified for flying duty or for flying training except under the following policy.

Individuals in training, or applying for training, must first complete a full course of treatment, which under existing regulations is six months, and a period of observation which is also six months. Spinal fluid must be negative at the end of treatment. Having satisfied these requirements, the applicant for training can be accepted for such training if waiver is granted by the Commanding General of the Army Air Forces.

The following policy applies to individuals who are already qualified (trained) for full flying status—individuals with early syphilis (primary and secondary), and latent syphilis (spinal fluid negative), may perform flying duty under the following provisions:

All infected individuals will be suspended from flying duty until in the opinion of the flight surgeon they are physically capable of performing such duty. Suspension for an initial minimum treatment period of four weeks will be observed in all cases. Each case will be considered on its own merits. Only those cases considered well adjusted to treatment and free from all clinical signs and symptoms of active syphilis at the expiration of the initial period of suspension will be considered for return to flying duty.

Individuals undergoing treatment who are returned to flying duty will not be permitted to accomplish such duty for a twenty-four-hour period subsequent to an arsenical injection. The flight surgeon will informally examine each individual following each arsenical injection, immediately prior to resumption of flying duty.

Individuals on flying status undergoing treatment for syphilis will be limited to such flights as do not interfere with the regularity and continuity of their treatment. Individuals failing to take regular treatment will be recommended for suspension from duty involving flying. In the event of change of station within the continental limits of the United States, the flight surgeon will immediately forward all pertinent medical data to the flight surgeon of the station to which the individual is ordered.

Clinically-active syphilis of the major anatomic systems affects normal physiology, increases the likelihood of disturbances characteristic of flight, and generally impairs the qualities and abilities required of the flyer. On the other hand, the question is not so clear as regards primary, secondary, and latent syphilis. Unfortunately, the microscopic lesions in vital tissues in these stages of syphilis are not easily demonstrated or evaluated, and their possible influence on function is equally subtle and difficult of evaluation. Early lesions of

syphilis, such as iritis, hepatitis, meningitis—with or without cranial nerve involvement—obviously would render the individual incapable of flying. However, the question which is unanswerable on the basis of exact information is whether the individual with early syphilis, in the absence of obvious lesions, such as those mentioned above, is physically fit to fly. Are the sub-clinical microscopic lesions which we know to be present throughout the body in untreated early syphilis so innocuous that they will not result in disturbance of function under flying conditions? The same question can be asked in reference to latent syphilis. We have been unable to find either experimental or clinical and practical evidence which would throw any light on this question. It has been generally assumed that such individuals are unfit for flying, and completion of treatment has always been required before flying duty is allowed. It is equally true that we have no evidence upon which to base the decision regarding the question of how much treatment such individuals require and how much time must elapse before such individuals may safely fly. The present policy, outlined above, was based essentially upon assumptions as to what was probably the right answer and upon practical needs of the moment.

Drugs as Related to Flying

Having selected the physical criteria and having found individuals who satisfy these criteria, and whose physical condition will remain satisfactory so long as treatment is continuous, the major question that remains is the role of drugs which may be needed for treatment. The influence of drugs in flying personnel must be considered with the following points in mind:

- (1) Drugs as they influence normal physiology.
- (2) Drug toxicity reactions as they influence normal physiology.
- (3) Drugs as they influence disturbances characteristic of flight.

It is not within the intent or scope of this paper to present a comprehensive discussion of this complex question, but rather to outline current practices and cite the evidence on which these practices are based. Information on many important aspects of the subject is admittedly fragmentary.

Antisyphilitic Drugs

Present Army treatment of syphilis employs arsenic (mapharsen) and bismuth. Bismuth in therapeutic doses is almost entirely free of reactions and pharmacologic effects which would be of significance in the discussion. Except for local pain at site of injection, and rare reactions such as pulmonary embolism, grippe syndrome, and nephrosis, it can be dismissed as of no practical importance.

Reactions which occur as a result of mapharsen administration are nausea, vomiting, diarrhea, vertigo, urticaria and angioneurotic edema, jaun-

dice, hemorrhagic encephalitis, blood dyscrasias, and exfoliative dermatitis. Most of these are extremely uncommon—so rare that they have not influenced decisions in this subject. (For example, the following data are found in Moore's recent text, *The Modern Treatment of Syphilis*, by Charles C. Thomas, 1943. During the period 1937-40, in an experience with 64,000 injections, mostly mapharsen, in 4,800 individuals in the Johns Hopkins material, there were no deaths. United States Navy figures for the period 1935-38 show an incidence of exfoliative dermatitis of 0.053 per 1,000 injections—a total of 56,290 injections of mapharsen having been given. Moore reports 56,290 injections of mapharsen without a single case of jaundice. Blood dyscrasias have been reported, but are extremely rare.) Nausea, vomiting, and diarrhea are common enough in the first twelve to twenty-four hours following administration to warrant consideration. Such reactions in the individual doing ground duty are of relatively minor importance, and most patients who suffer from them are not seriously disabled. For the individual who must perform duty in the air, fly to high altitudes and wear an oxygen mask, they may be of considerable significance, and would, in fact, often lead to serious consequences. Since they occur almost entirely during the first twenty-four-hour period following injection, the policy of grounding of personnel during this period has a sound basis.

Occasional febrile reactions which would increase oxygen needs at high altitudes usually have their onset within the twenty-four-hour period, and it is believed are provided for in the present policy. The majority of instances of idiosyncrasy and serious intolerance to the arsphenamines appear during the first ten to twelve injections. The present Army treatment schedule provides that the individual receive two injections a week. Thus, in the first four weeks (eight injections) it was presumed that most of the individuals who would develop serious reactions would be recognized in this period.

Sulfonamides

Because of the great incidence of gonorrhea and the widespread use of sulfonamides in its treatment, this subject is of major importance. Present Army Air Forces' regulations provide that individuals required to perform flying duty will be grounded during and for six days following the last dose of sulfonamide administered systemically. In addition, it is generally true that the disease itself for which the sulfonamide is being given would be of sufficient seriousness to require a period of grounding and convalescence of at least six days following sulfonamide medication. This, however, is not true of gonorrhea, and the decision it seems should better be based on the clinical judgment of the flight surgeon, rather than on an arbitrary rule.

Early evidence indicated that sulfonamides in therapeutic doses reduced altitude tolerance and impaired coordination, ocular muscle balance for

near vision and depth perception, mental processes, muscle coordination, et cetera. Much of this evidence was of questionable nature, and most of it based on experience with sulfanilamide.^{1,2,3,4,5,6,7,8,9}

Since sulfanilamide has been almost entirely displaced by the newer derivatives, such as sulfathiazole and sulfadiazine, the present policy must be re-examined in the light of experience and laboratory studies with the new drugs. It is now known that sulfathiazole and sulfadiazine are almost completely excreted within forty-eight hours after the last dose, and numerous studies have indicated that moderate doses have little or no effect on altitude tolerance, visual acuity, depth perception, muscular coordination, mental processes, et cetera.^{10,11,12,13,14,15,16} It appears, therefore, that prophylactic doses of sulfonamides used as preventives of epidemic respiratory diseases and gonorrhea would not make flying unsafe, and that since the drugs are fully excreted within forty-eight hours after the last dose in therapeutic use, and that drug effects do not last beyond this period, a change in the present policy should be considered. In such circumstances return to flying duty would be governed by the status of the patient and not by the time interval following sulfonamide administration.

Penicillin has almost completely changed the perspective in regard to gonorrhea in flying personnel. The vast majority of cases can be cured with 100,000 units of penicillin, and this dosage is

completely free of untoward reactions. Thus, flying personnel can return to flying duty immediately upon completion of treatment. Since the beginning of 1944, penicillin has been available for the initial treatment of gonorrhea in flying personnel, and this fact has been responsible for a dramatic reduction in time lost from duty by flying personnel. It has also enabled air crews en route to overseas destinations to remain intact and move out without the delay which formerly resulted from the necessary period of treatment and post-treatment observation and grounding with sulfonamide therapy.

Practical Experience

There are no verified reports of air accidents which can be attributed to venereal diseases or the drugs used in their treatment. Several such reports have been investigated, and in no instance has the disease or drug been proved to have been the proximate cause of the accident. However, the nature of air accidents is such that it is usually impossible to determine what role, if any, medical factors play. Explosion, incineration, and death of all occupants occurs too often. About eighty per cent of all air accidents are attributable to "pilot error"—usually error in judgment or faulty technique. Medical causes would fall in these categories, and might be responsible for either. It is usually impossible to determine the proximate cause of errors in judgment or faulty techniques.

The fact that we are unable to prove the role of venereal diseases and their treatment in air accidents does not necessarily prove that they are not implicated, but it must be admitted that our evidence is entirely circumstantial and deductive.

¹ *J.A.M.A.*, **116**:2279, 1941—Editorial Comment.

² *J.A.M.A.*, **119**:1431, (August 22) 1942—Editorial Comment.

³ Spellberg, M. A.: Toxicity of Sulfanilamide. Severe Transient Myopia following Use of Sulfanilamide, *III. M. J.*, **75**:366, 1939.

⁴ Bloom, W. A.; Leech, M. P., and Shaw, W. J.: Temporary Blindness Due to Sulfathiazole, *J. Missouri M. A.*, **38**:202, 1941.

⁵ Reynolds, F. W.; Evans, Mildred S., and Walsh, Frank B.: Chemotherapeutic Prophylaxis with Sulfonamide Drugs. I. The Effect of Small Dose of Sulfathiazole or Sulfadiazine on Visual Efficiency, *Am. J. Syph., Gonorr. and Ven. Dis.*, **27**:2, (Jan.) 1943.

⁶ Medical Research Laboratory, Naval Air Training Center, Pensacola, Florida (10) (AV-R7-1), January, 1943. Second Report. The Effect of Sulfathiazole upon "Altitude Tolerance" Determined by Flicker Fusion Tests.

⁷ School of Aviation Medicine, Project 76, Report No. 1, February 23, 1943, The Effect of Sulfonamide Drugs on Anoxia Tolerance: Effects of Prophylactic Doses of Sulfanilamide, Sulfapyridine, Sulfathiazole and Sulfapyrazine.

⁸ AAF Material Center (Exp. Eng.) Exp. M-49-695-5A, August, 1942, Effect of Sulfonamides on Blood Pigment, Oxygen and Carbon Dioxide Capacity of Dogs and Humans.

⁹ Wagener, H. P.: Ophthalmology: Toxic Effects of Sulfonamides on the Eyes, *Am. J. Med. Sci.*, **206**:26, (August) 1943.

¹⁰ School of Aviation Medicine—Project 91, Report No. 2, December 22, 1942, Sulfonamide Drugs and Dark Adaptation.

¹¹ School of Aviation Medicine, Project 99, Report No. 1, December 26, 1942. The Effect of Sulfathiazole and Sulfadiazine on Visual Fields, Ocular Mobility and Depth Perception.

¹² School of Aviation Medicine, Project No. 76, Report No. 2, February 23, 1943. Effect of Sulfonamide Drugs on Anoxia Tolerance: Effect of Therapeutic Courses of Sulfathiazole and Sulfadiazine.

¹³ School of Aviation Medicine, Project 105, No. 1, January 26, 1943. Absorption and Excretion of Single Doses of Sulfathiazole, Sulfadiazine and Sulfapyrazine.

¹⁴ Macht, David I.: Effects of Sulfonamides on Cerebral and Neuromuscular Reactions, *Exp. Med. & Surg.*, **1**:260, (August) 1943.

¹⁵ Hofkesbring, R.; Greisheimer, E. M., and Wertenberger, Grace E.: The Effects of Various Sulfonamides on the EKG of the Dog, *Am. Heart Journ.*, **26**:333, (September) 1943.

¹⁶ Goodman, L. S., and Gilman, Alfred: *The Pharmacological Basis of Therapeutics*. New York, Macmillan Co., 1941.



THE EFFECT OF DIET ON GASTRO-INTESTINAL SYMPTOMS AT ALTITUDE

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It is unfortunate that "gas on the stomach" has always been a subject for humor, for although it rarely kills, it can cause extreme discomfort. Possibly because of its somewhat ridiculous place in the role of symptoms it has received very little scientific attention. The theories as to its cause are multiple and largely unsubstantiated.

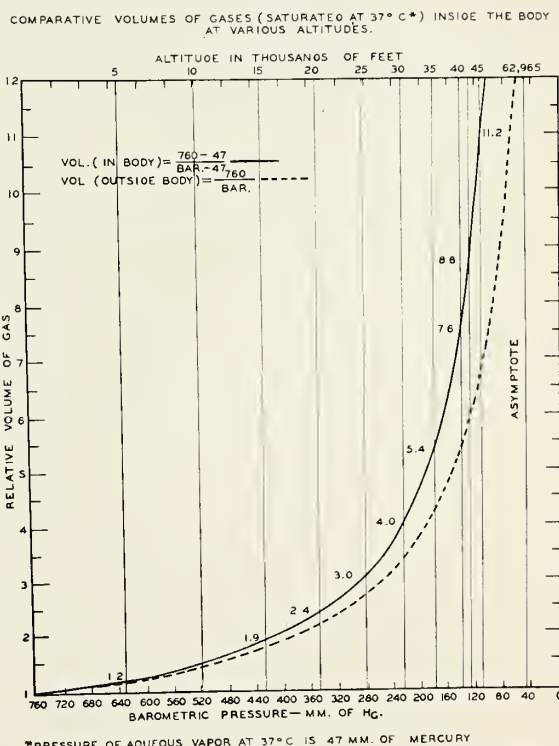
In ascent to altitudes, gastro-intestinal gas may cause important symptoms, a fact pointed out by Paul Bert.¹ The possibility of the expansion of intestinal gases on ascent (due to the decrease of pressure) as an etiologic factor in altitude sickness was suggested by numerous authors. Clissold,² as well as Lepileur and Speer,² believed that the expansion of gases would hamper respiration and circulation considerably. Maissiat² stated that the intestinal gases could distend to the point of rupture of the viscus. Colin² saw the cause of death in altitude sickness as a forcing upward of the diaphragm by the expansion of gas. Bert emphasized that the latter could not happen because of the double communication of the intestinal tract with the exterior. He describes swelling of the abdomen due to expansion of intestinal gases occurring in animals subjected to extreme decompression. He also describes the same phenomenon in himself and others when subjected to decompression, but states that it never brought serious inconvenience. Gilbert³ mentions that eructation and passing of flatus will not wholly relieve the abdominal fullness caused by expansion of intestinal gases.

Andreiev and Trophemouk⁴ speak of the pain and colic due to the expansion of gas in the intestinal tract occurring at altitude. They recommend avoidance of gas-forming foods such as cellulose, the eating of meals one to two hours before ascent, and the emptying of the bowel as a means of preventing excessive gas formation. McDonough⁵ found

no relation between the amount and location of gas and abdominal pain at altitude. Grow and Armstrong⁶ recommend avoidance of coarse vegetables, all varieties of beans, highly-spiced or greasy foods, and carbonated beverages. Von Diringshofen⁷ also mentions the avoidance of voluminous foods which tend to the formation of gas in high altitude flights.

Thus, it can be seen that various opinions are held as to the value of diet and the role of gas in aviation medicine. However, there are certain known facts governing this. Boyle's law states that at a constant temperature the volume of a gas varies inversely as the absolute pressure exerted upon it. During ascent the gases in the stomach and intestine expand with altitude, as shown in Figure I and Table I. As an example, an individual at an altitude of 18,000 feet would have the volume of gas in his gastro-intestinal tract doubled as

FIGURE I



¹ Bert, Paul: *Barometric Pressure*, Columbus, Ohio, College Book Co., 1943.

² Clissold, Lepileur, and Speer, Maissiat (Quoted by Bert, Paul): *Barometric Pressure*, Columbus, Ohio, College Book Co., 1943.

³ Gilbert, E.: für Kenntniss der Einflüsse der Luftfahrt auf den menschlichen Organismus, *Med. Welt.* 7:440-443, 1933.

⁴ Andreiev, V., and Trophemouk, M.: L'alimentation de l'aviateur aux hauts altitudes, *Voenna san Delo* 2:3, 1936.

⁵ McDonough, F. E.: Roentgenographic Observations on the Amount and Distribution of Intestinal Gas at Altitudes in Relation to Abdominal Symptoms, *AAFSAM Research Project No. 193*, Report No. 1, (Nov. 1) 1943.

⁶ Grow, M. C., and Armstrong, H. G.: *Fit to Fly*, New York, D. Appleton-Century Co., p. 83, 1941.

⁷ Von Diringshofen, H.: *Medical Guide for Flying Personnel*, Toronto, The University of Toronto Press, p. 94, 1940.

TABLE I

COMPARATIVE VOLUMES OF GASES (SATURATED AT 37°C*)
INSIDE THE BODY AT VARIOUS ALTITUDES

Barometric Pressure		Relative Volume of Gas Saturated With Water Vapor
mm. Hg.	Altitude Feet	
760	0	1.0
635	5,000	1.2
523	10,000	1.5
429	15,000	1.9
349	20,000	2.4
282	25,000	3.0
226	30,000	4.0
179	35,000	5.4
141	40,000	7.6

* Pressure of aqueous vapor at 37°C is 47 mm. Hg.

compared to ground level. In an analysis of a large number of runs in the decompression chamber to simulated altitudes of 38,000 feet, 37 per cent were terminated by symptoms—abdominal pain causing 15 per cent of the total number of descents. Although only about 15 per cent chamber runs are terminated because of abdominal pain, symptoms pertaining to the abdomen, such as distension and distress, are encountered more frequently than any other complaint, occurring in about 50 per cent of the runs. It must be realized that in the majority of cases the abdominal symptoms are comparatively mild; yet it also must be realized that abdominal symptoms, even though mild, may cause sufficient trouble to decrease the efficiency of the air crew and thus assume increased importance in military aviation.

The object of this study was to determine the effect of diet on the gastro-intestinal symptoms appearing at altitude. Specifically, it was to determine the effect of the meal, taken within a few hours of ascent, on these symptoms. In general, the diets were of two types. In one the diet consisted of gastro-intestinal irritating foods (Table II). This diet would fall in the category commonly known as a gas-producing diet. That these foods are actual gas formers in the gastro-intestinal tract has never been satisfactorily proved. Yet it is known that these foods will cause gastro-intestinal symptoms in a much higher percentage of persons than a bland diet. The second type diet consisted of bland foods (Table III). The ascent in the decompression chamber was to a simulated altitude of 38,000 feet at a rate of ascent of 2,500 feet per

TABLE II

GASTRO-INTESTINAL IRRITATING MEAL

Carbonated Beverage.
2 Fried Pork Chops.
1 Fresh Roll—1 Pat Butter.
Navy Beans (Prepared).
Cole Slaw (Vinegar, Pepper and Salt).
1 Lettuce Leaf.
Raw Apple.

minute. The subjects were instructed to sit still during the chamber run, for it has been found that moving around promotes the expulsion of gas. The subjects were kept at this altitude for fifteen minutes. It was not believed that a longer period of time at this altitude was necessary, as in our observations any gastro-intestinal symptoms that occur will appear within the first fifteen minutes. An individual with any history of significant gastro-intestinal disease was eliminated from the study. The men taking part in the investigation were requested to eat a breakfast consisting of an orange or grapefruit, cereal, toast, bacon, coffee or milk. There was no control over the meal eaten the evening previous to the chamber run, for the sole purpose of this study was to determine the effect of the meal, prior to flight, on the individual. The subjects were questioned concerning the gastro-intestinal symptoms occurring during the chamber run. The symptoms specifically mentioned were abdominal discomfort, abdominal swelling, nausea, excessive eructation or excessive flatus. Any other signs or symptoms occurring were noted. It was impossible to conceal from the subjects which was the gastro-intestinal irritating meal and which was not. Therefore, the element of suggestion, that is, if a man eats beans he has gas, could not be eliminated. On the other hand, it is not thought that in this study the psychological element should be eliminated. We were interested in knowing whether or not a man going to altitude on such a diet had distress—not whether it was a psychological or physiological process.

TABLE III

BLAND MEAL

Roast Beef (No Gravy).
Mashed Potatoes.
Pureed Carrots.
Stewed Pear.
Baked Custard.
1 Slice Buttered Toast—White.
1 Glass Milk.

The study was divided into two parts. In the first part the subjects were fed a meal consisting of either gastro-intestinal irritating foods or bland foods. Two to three hours later they were taken up in the decompression chamber, according to the method described above. Two days later they were given the alternate type of meal and again taken up in the decompression chamber. The type of meal given first was alternated with each group to rule out the factor of anxiety occurring with the initial run. The subjects were questioned concerning abdominal discomfort at the end of each chamber run, and also at the end of the second run were asked to compare the severity of gastro-intestinal discomfort in the two runs. Of the twenty-eight individuals studied in this way, twenty-one had significantly less discomfort with the bland diet, four noticed no difference, and three had less discomfort with the gastro-intestinal irritating meal

TABLE IV

Discomfort	Bland Meal	Gastro-intestinal Irritating Meal	Total
Yes	3	21	24
No	25	7	32
Total	28	28	56

than with the bland meal (Table IV). On the basis that 50 per cent of the difference will favor the bland meal and 50 per cent the gastro-intestinal irritating meal, we find that the 75 per cent who actually favored the bland meal is significantly larger than the expectation.

The second part of the study consisted of taking one group of individuals up in the chamber, as described above, in the morning two to three hours after breakfast. They were then fed a gastro-intestinal irritating meal, and two to three hours later again taken up in the chamber. The subjects were questioned as to the occurrence of gastro-intestinal symptoms at the end of each run and asked to compare the severity of symptoms occurring with each run. The second group of individuals went through the same procedure except that they were fed a bland meal instead of a gastro-intestinal irritating meal. It should be pointed out that the original control chamber run in the morning would tend to lessen the gastro-intestinal symptoms occurring in the afternoon run because of the expansion and consequent expulsion of gas occurring in the morning run. As this took place in both groups fed on a gastro-intestinal irritating meal and on a bland meal, it is not believed that this affects the final results. In the first group (Table V) of sixty who were fed the gastro-intestinal irritating meal, forty-three noticed an increase in gastro-intestinal symptoms occurring during the chamber run after the meal. Seventeen noticed no increase in symptoms or had no symptoms referable to the gastro-intestinal tract. In the second group (Table V) of fifty-four individuals who were fed a bland diet, fifteen noticed an increase in gastro-intestinal symptoms. Thirty-nine had no increase in symptoms, as compared with the control run, or had no symptoms on either run.

It should be emphasized that in the second part of the study the gastro-intestinal symptoms compared after the chamber runs were not solely ab-

dominal discomfort, as was compared in the first part of the study, but included any symptoms referable to the gastro-intestinal tract. This is demonstrated in Table VI where thirty-one had abdominal distress after a gastro-intestinal irritating meal, and thirty-three did not. Yet, comparing this to the control run where only eleven had abdominal distress and fifty-three did not, it is seen to be significant. The greatest difference took place in the less clinically-significant type of symptoms, such as abdominal distension, excessive eructation, and flatus.

SUMMARY

One aspect of the effect of food on abdominal symptoms occurring at altitude that could not be studied in this group is the factor of personal idiosyncrasy to certain foods, and in dealing with large groups, as is necessary in aviation, it is impossible to deal with this problem individually other than to point out that foods that are known to disagree with an individual should be avoided prior to flight. Another factor that can not be controlled in a study of this type is the effect of emotions on the gastro-intestinal tract.

No attempt was made in this study to determine the gas-producing qualities of specific foods. The sole purpose was to determine the effect of foods that are at one extreme in their frequency of causing abdominal distress as compared to foods at the other extreme in not causing abdominal distress on the gastro-intestinal symptoms encountered at high altitudes. In other words, is it necessary for the air crew going to high altitudes to be careful concerning the food eaten immediately prior to flight? In this study, as has been found in other studies, a comparatively large number have gastro-intestinal symptoms, but in comparatively few are these symptoms of sufficient severity to terminate a mission. Yet it must be realized that a gunner with a "belly ache" is not as good a gunner as one without a "belly ache," and a bombardier with an abdominal cramp is not as good a bombardier as one without an abdominal cramp. In comparing the effects of the gastro-intestinal irritating diet and the bland diet on the abdominal symptoms occurring at high altitude, a significant number had aggravation of their symptoms or production of new symptoms with the gastro-intestinal irritating diet. It does not mean that every individual eating this type of food will have abdominal discomfort on going to altitude, nor will every individual on a bland diet go to altitude with freedom from gastro-intestinal symptoms, but it does suggest that a larger number of individuals on gastro-intestinal irritating foods will have abdominal discomfort than when on a bland diet. The individual in whom this would assume the greatest importance is the person who frequently has some type of gastro-intestinal distress at altitude. In all likelihood a gastro-intestinal irritating meal would significantly increase his difficulty.

TABLE V

<i>Increased Gastro-intestinal Symptom</i>			<i>Total</i>
	Yes	No	
Gastro-intestinal irritating meal	43	17	60
Bland meal	15	39	54

TABLE VI

	Gastro-intestinal Irritating Foods		Control		Bland Foods		Control	
	Positive	Negative	Positive	Negative	Positive	Negative	Positive	Negative
Abdominal distress	31	33	11	53	19	40	9	50
Abdominal swelling	46	18	29	35	29	30	25	34
Nausea	0	64	1	63	0	59	0	59
Excessive belching	53	11	43	21	30	29	45	14
Excessive flatus	46	18	31	33	43	16	38	21

CONCLUSIONS

1. Subjects fed on a gastro-intestinal irritating meal and a bland meal had less abdominal discomfort with the bland meal when taken to 38,000 feet in a decompression chamber.
2. A group of subjects fed on a bland meal had fewer and less severe gastro-intestinal symptoms

than did a group fed on a gastro-intestinal irritating meal when taken to 38,000 feet in a decompression chamber.

3. It is suggested that individuals who are susceptible to abdominal distress prior to high altitude flights should avoid foods commonly known to be irritating to the gastro-intestinal tract.

Landing at Lae



THE REACTIONS OF THE NASOPHARYNX TO HEAT, COLD, AND DISEASE WITH SOME THERAPEUTIC CONSIDERATIONS

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As man rapidly becomes master of the phenomenon of flight, so should the flight surgeon become familiar with the important structure, the nasopharynx. As late as 1939, Carmody¹ was able to speak of the epipharynx as "The Almost Unknown in Otolaryngology." The purpose of this paper is to propose a functional concept of this area and to present some of the physiological and pathological responses of the nasopharynx to heat, cold, and disease, together with some therapeutic considerations.

ANATOMY

The nasopharynx is formed above by the basilar process of the occipital bone and by the body of the sphenoid bone, posteriorly by the cervical vertebrae, and anteriorly by the choanae and the soft palate. Inferiorly, the nasopharynx is continuous with the oral pharynx.²

The superior wall extends laterally along the body of the sphenoid bone and petrous portion of the temporal bone. The lateral limit is reached at a point near the osseous carotid canals. The posterior wall extends downward and slightly backward, corresponding to the base of the skull, anterior to the foramen magnum and the inclination of the cervical vertebrae.³

On the lateral walls of the nasopharynx, behind the posterior tips of the inferior turbinates, are the eustachian tubal orifices. Slightly above and behind the orifices on either side is a small ridge, formed by the eustachian cartilage, called the "eustachian cushion." The salpingo-pharyngeal fold extends downward and forward in front of the eustachian orifices.

The depression at the angle of the nasopharynx between the posterior ridge of the eustachian cartilage and the posterior wall of the nasopharynx is known as the "fossa of Rosenmüller."²

Lymphoid tissue (adenoid) is found in abundance on the roof and posterior wall of the nasopharynx. This tissue attains considerable size, especially in children.

The nasopharynx communicates with the eustachian tubes laterally, anteriorly with the right and

left nasal cavities, and inferiorly with the oral pharynx.

The chief blood supply is derived from the ascending pharyngeal and faucial branches of the external carotid, and the superior palatine artery, a branch of the internal maxillary artery. The main nerve supply stems from the trigeminal nerve and the glossopharyngeal nerve.

HISTOLOGY

The mucous membrane lining the nasopharynx is continuous with that lining the nasal cavities and sinuses. It is pseudostratified ciliated columnar epithelium, consisting of a basement membrane resting upon a thin layer of connective tissue.

The cells are closely packed within the epithelial layer, and this results in the difference of level of cellular nuclei and a loss of cellular size. Some of the cells which remain attached to the underlying connective tissue have lost their connection with the free surface. These cells, known as supporting cells, are covered by the taller superficial cells.

Goblet, mucous and ciliated cells are freely interspersed between the supporting cells. Mucous glands are situated in the deeper layer. A strong basement membrane, colloidal in nature, lies between the epithelial and subepithelial layers.⁴

PHYSIOLOGY

The nasopharynx physiologically may be thought of as a part of the nose, and also as a part of the pharynx. It may be included, likewise, in the physiological functionings of the eustachian tube, middle ear, and mastoid, as the eustachian tubal orifices are included within its lateral walls. The mucous membrane lining the nasopharynx is continuous with that of the nose, sinuses, eustachian tubes and the oral pharynx. From the above it becomes obvious that the nasopharynx is the keystone of the ear, nose, and throat, and that any disturbances in the normal function of the nasopharynx is capable of influencing the function of any of the above-mentioned structures. By its very anatomical position, the nasopharynx assumes a position of great clinical significance in flying personnel.

PATHOLOGY

Acute inflammation is a continuous process that occurs in three stages: hyperemia, exudation, and

¹ Carmody, T. E.: The Epipharynx—The Almost Unknown in Otolaryngology, *Transactions of American Academy of Ophthalmology and Otolaryngology*, 44:235-264, 1939.

² Ballenger, H. C.: *Otology, Rhinology and Laryngology*, Philadelphia, Lea and Febiger, 1940.

³ Lederer, F. L.: *Diseases of the Ear, Nose and Throat*, Philadelphia, F. H. Davis Co., 1938.

⁴ Bloom, Maximow: *Textbook of Histology*, 2nd edition, Philadelphia, W. B. Saunders Co., 1934.

finally resolution or repair.⁵ The initial response of any mucous membrane is a very transient vasoconstriction. This is rapidly followed by vasodilatation or hyperemia, with a resulting decrease in the rapidity of blood flow and the adherence of leukocytes to the vessel walls.

During the stage of exudation there is an increased permeability of the capillaries with migration of the leukocytes through the walls of the vessels into the surrounding stroma. There is also an escape of serum with resulting edema. Macrophages and large mononuclear cells appear in the extravascular spaces after a period of two or three days. Fibrin appears in varying amounts, depending upon the causative agent. As the inflammatory reaction progresses, additional large monocytes and fibrocytes appear and the process of resolution begins.

If the inflammation becomes chronic, fibrous tissue is laid down and there is a budding of new capillaries which results in a very vascular mucous membrane containing many lymphocytes and plasma cells.

McMahon⁶ has shown by studies on the nasal mucous membrane of the rabbit that the principal reaction to infection occurs in the perivascular connective tissue elements of the mucous membrane, particularly in the subepithelial areolar tissue. He has further shown that foreign particles are phagocytized in the subepithelial spaces by the histocytes, fibroblasts and monocytes; that the ciliated cells are not phagocytic.

It is essential that one appreciate the numerous physical and chemical factors which are continually operating to alter the physiological function of the mucous membrane of the nasopharynx. These various factors act as predisposing causes, and all embody elements concerned with (1) exposure to infection, and (2) lowering the general as well as the local tissue resistance.

Among the factors tending to lower the resistance may be mentioned loss of sleep, worry, overwork, excessive use of alcohol, overeating and improper diet. Chilling of the body surfaces will result in the defensive mechanism of the body being impaired with resulting ischemia and vascular constriction, which in turn produces both a drying of the nasopharyngeal mucous membrane and nasal congestion.

In addition to the above-mentioned factors, flying personnel are exposed to rapidly changing temperatures, and to cold temperatures far in excess of the average thermal changes experienced by ground personnel. A flyer's body may be warm and protected from the elements by clothing, yet the naso-

pharynx may be exposed to the chilling effects of the inspired air.

While flying with the oxygen mask applied to the face, the added factor of excessive drying of the nasopharyngeal mucosa is ever present.

EFFECT OF COLD

The continual inhalation of cold air results in a congealing of the mucus normally present in the nasopharynx. Thus the mucus blanket becomes retarded in movement. The lower temperature of the inspired air rapidly results in the slowing of the ciliary activity, even to the point of total inhibition. The metabolism of the individual cells is lowered, and there is an actual vasoconstriction of the small blood vessels. The waste products of metabolism accumulating within the cells and intercellular spaces are not carried off rapidly because of the decreased blood supply, and thus a local toxic reaction is produced.

The end result of chilling is the establishment of a fertile bed in which viruses and bacteria grow and multiply.

THE EFFECT OF DRYING

The necessity at high altitudes of using 100 per cent oxygen with the oxygen mask and demand-type regulator may produce drying of the nasopharyngeal mucosa in some instances sufficient to be somewhat annoying after a two-hour period.

The continual inhalation of this moisture-free oxygen produces a profound drying of the mucosal blanket with resulting fissuring. Ciliary recovery from exposure to drying is less rapid than following exposure to cold. The ciliated epithelium is at first inhibited, and if exposed over a sufficient period of time to this drying effect is actually killed. Once the cilia have been destroyed, regeneration of the ciliated epithelium is a long and tedious process.

The drying and fissuring of the mucous blanket and retardation, or actual destruction, of the ciliated epithelium permits of virus and bacteria invasion with the subsequent development of acute inflammation within the substance of the nasopharyngeal mucosa.

Deviation of the nasal septum, septal spurs, nasal polypi, hyperplastic and hypertrophic changes within the nasal cavities all mechanically interfere with the normal air pathways and produce a drying effect upon the nasopharyngeal mucosa.

Any obstruction to the nasal cavity results in stagnation of discharges and an increase of bacterial flora within the nasopharynx. This fact serves to explain in part Carmody's statement that "frequently cultures from the epipharynx give us the offending organism in greater profusion than can be found in the nose or pharynx."¹

SYMPTOMS

The very earliest symptom of an acute inflammation of the nasopharynx is a feeling of dry irritation of the back of the nose and the roof of the mouth. As a result of this symptom, the victim may

⁵ Ash, J. E.: *Atlas of Otolaryngic Pathology*, 2nd edition revised, Army Medical Museum, Office of the Surgeon General, 1939.

⁶ McMahon, J. B.: *The Spread and Phagocytosis of Particulate Matter in Nasal Mucous Membrane of the Rabbit*, Saint Louis, Annals Publishing Company, 42:660-679, 1933.

irresistibly rub the roof of the mouth with his tongue. The act of swallowing exaggerates the annoyance or pain. Systemic reaction is lacking during this stage and the temperature is not elevated.

Within twelve to twenty-four hours a general feeling of malaise develops. The temperature is usually elevated 99° to 99.4° F. and a feeling of "dullness in the head" is experienced. This may progress within eight to twelve hours to an occipital and frontal headache with accompanying soreness extending down the back of the neck, even into the shoulders, and in some instances the soreness is noted in the arms.

An increase in a mucoid or mucopurulent postnasal discharge is experienced, and as a result there is a constant effort on the part of the individual to clear his throat. As the inflammation spreads to involve the mucous membrane of the eustachian tubes, there is a feeling of fullness of the ears and in some instances even tinnitus. True pain in the ear is not a symptom which is commonly encountered in cases of acute inflammation of the nasopharynx.

In the cases which have a profuse purulent discharge from the nasopharynx, accompanied by crusting and even ulceration of the nasopharynx, the victims appear to be extremely ill. The temperature is elevated to 100°-102° F., pallor is noticeable, and there is obvious dehydration. Pain and fullness of the ears is outstanding with an associated conductive deafness. Occipital headache is most severe, and torticollis is frequently seen. The cough is productive and the sputum is mucopurulent in character.

NASOPHARYNGEAL EXAMINATION

Examination of the nasopharynx, employing both the Holmes' nasopharyngoscope and the postnasal mirror, may reveal a mucous membrane which appears to be normal. This, of course, is due to the fact that the existing pathology is deep within the tissue. Later, however, the mucous membrane will show localized signs of inflammation which rapidly become diffuse. The discharge becomes tenacious, and the surface of the membrane presents a glistening dry appearance. If the infection is pyogenic, the discharge becomes purulent and the surface of the mucous membrane dries and forms crusts with subsequent ulceration. This ulceration of the mucous membrane becomes apparent after the crusts and discharge have been wiped away.

TREATMENT

All therapy should be directed toward (1) the promotion of ventilation and drainage of both the nasal cavities and the sinuses; (2) local therapeutic measures to the nasopharynx; (3) general systemic therapeutic measures; and (4) medical or surgical eradication of the causative factors of nasopharyngitis.

Ventilation and drainage of the nasal cavities and associated sinuses should be accomplished by

shrinkage of the nasal mucous membrane by spraying with any of the available vasoconstrictors, such as neosynephrin ¼ per cent, ephedrine sulfate 1 per cent, isophrin 1 per cent, or tuamine sulfate 1 per cent. A cotton pledget pack, containing the vasoconstrictor solution, should then be placed in the middle meatuses in order to promote sinus drainage.

Local treatment of the nasopharynx should then be instituted as follows: weak solutions of astringents or the therapeutic agents of choice; silver nitrate ¼ per cent, methylene blue aqueous 2 per cent, gentian violet aqueous 2 per cent. H. D. Smith, of the AAF School of Aviation Medicine, has had excellent results with the powered sulfanilamide, and E. Ebert⁷ and M. S. Freeman⁸ have used sulfathiazole powder. D. A. Dolowitz *et al*,⁹ and F. M. Turnbull, *et al*,¹⁰ have used various sulfonamide solutions which have been stabilized and buffered.

Heat applied in the form of short wave or actual warm irrigations of normal saline to the nasopharynx, with the patient in the head-low position, accomplishes several things physiologically. The metabolism of the nasopharyngeal mucosa is increased. This results in an increased flow of mucus, the result of stimulation of the goblet cells of the membrane. The individual cell metabolism is increased with the following increase in histamine-like ("H") substance and other waste products. These of necessity must be eliminated from the cell.

The "H" substance acts primarily upon the endothelial lining of the capillaries, but this in itself will not increase the amount of blood flow to the area. By "Axon reflex" the "H" substance is thought to dilate the arterioles, which increases the blood supply to the given area. As the katabolites are removed from the cells there is a decreasing stimulation from the "H" substance with a decrease in the amount of blood flowing to the nasopharynx.

General measures, such as sedatives, aspirin, and the mild cathartics should be used as adjuncts. Bed rest is advised when the temperature is elevated above 99° F. The patient should be warned against exposure to drafts or chilling during the sleeping hours. Adequate fluids and a light high-caloric diet are advisable.

The causative factor or factors producing the nasopharyngitis should be searched for and, if

⁷ Ebert, E.: Local Treatment of Acute Rhinitis with Sulfathiazole, *Arch. of Otolaryngol.*, 38:4, 324-327, (Oct.) 1943.

⁸ Freeman, M. S.: Local Use of Sulfathiazole Powder for Acute Pharyngeal Infections, *Arch. of Otolaryngol.*, 37:496-501, (April) 1943.

⁹ Dolowitz, D. A.; Loch, W. E.; Haines, H. L.; Ward, A. T., and Pickrell, K. L.: The Prevention of Ear and Nasal Sinus Complications of the Common Cold, *J.A.M.A.*, 123:9, 534-536, (Oct. 30) 1943.

¹⁰ Turnbull, F. M.; Hamilton, W. F.; Simon, E., and George, M. F.: Sinusitis and Infections Secondary to the Common Cold, *J.A.M.A.*, 123:9, 536-537, (Oct. 30) 1943.

possible, eliminated. It is well to reiterate that nasal obstructions, latent sinusitis, and recurrent attacks of acute rhinitis all predispose to the development of nasopharyngitis.

Recently at the AAF School of Aviation Medicine, in the Department of Otolaryngology, thirty-two cases of acute nasopharyngitis were treated with insufflations of powdered sulfanilamide. A complete history was taken on every patient, followed by an otolaryngological examination, together with temperature recordings. Neosynephrin hydrochloride $\frac{1}{4}$ per cent was then sprayed into the nasal cavities, and this was followed by the insufflation of powdered sulfanilamide to the nasopharynx. All individuals were questioned very carefully as to the earliest subjective symptoms and the time of their onset. During the insufflation of powdered sulfanilamide extreme care was taken to apply the powder solely to the nasopharynx.

Twenty-one of the cases noticed the earliest onset of symptoms within twelve to twenty-four hours. Of these twenty-one cases, the commonest early symptoms were a dry or burning sensation localized in the back of the nose and an itching irritation of the roof of the mouth. These cases received one treatment of powdered sulfanilamide as outlined above and were again observed within twenty-four hours, and all of them were both subjectively and objectively relieved of the primary acute nasopharyngitis. Five cases reported to the clinic and gave the history of the onset of their symptoms forty-eight hours before. These individuals required two such treatments with powdered sulfanilamide before subjective and objective cure was accomplished. Five cases reported for treatment

and stated that they had had their symptoms for ninety-six hours or longer. These five cases required three or more treatments to accomplish an apparent abortion of the nasopharyngitis. In the series of thirty-two cases there was one failure with treatment as outlined.

COMMENT

The anatomical position of the nasopharynx facilitates the extension of an inflammatory process into the eustachian tubes, resulting in interference with middle ear aeration. This danger has been recognized by flight surgeons for a long time, so that the axiom "never fly with a cold" has evolved.

It is believed that all so-called "common colds" start primarily as acute inflammation of the nasopharynx and secondarily involve the nasal cavities, sinuses, and pharynx.

It is important to consider a postnasal drip as a sign of infection or irritation. This discharge may be originating within the sinuses and nasal cavities, but the possibility of a primary nasopharyngitis should be constantly kept in mind.

SUMMARY

A brief review of the anatomy, histology, physiology, and pathology of the nasopharynx is presented.

The effects of cold, drying, and heat are discussed.

The symptoms, physical findings, and some therapeutic considerations of acute nasopharyngitis are given, and a plea presented for early treatment.

The role of the nasopharynx as the keystone of the ear, nose, and throat infections has been emphasized.



Administering blood plasma to a wounded soldier aboard an air evacuation plane.

SULFADIAZINE PROPHYLAXIS OF ACUTE INFECTIOUS DISEASES*

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TRUAX FIELD, MADISON, WISCONSIN

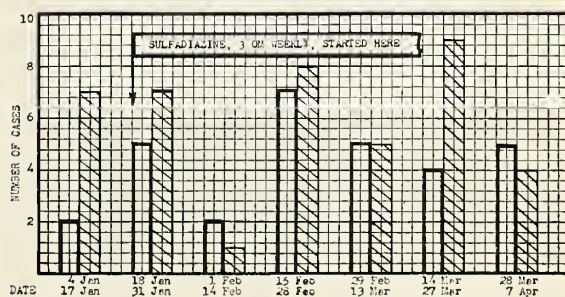
Epidemics of acute infectious diseases are a constant danger in army camps in wartime, when large groups of men are gathered together in crowded quarters. Under such conditions the air-borne respiratory diseases are particularly liable to rapid spread throughout the group. Recent investigations¹ have shown that most of these infections are transmitted in the dust of the barracks and from the bedclothing of the occupants. The usual early morning policing of the barracks serves to fill the barracks' air with the causative organisms and provides ideal circumstances for widespread exposure. Various methods have been recommended and shown to be effective in controlling this mode of spread. The use of oil-treated barracks floors^{2, 3} and treatment of the blankets with oil has served to reduce the air-borne infections. The use of aerosols, while effective, is difficult under the usual conditions in army installations. The use of chemotherapy as a preventive of these infections is another possible method of control. Several recent reports have shown the efficacy of small doses of sulfanilamide in controlling the recurrence of rheumatic fever.^{4, 5} In addition, reports have appeared indicating that sulfonamide compounds are effective in protecting scarlet fever contacts,⁶ preventing meningococcal infection⁷ and gonococcal and chancroidal infections.^{8, 9} It therefore seemed probable

that sulfonamide compounds might be effective in controlling the spread of acute infectious diseases among a large group of soldiers. This communication is a report of our experiences in the use of sulfadiazine in controlling both sick call and hospital admissions from acute infectious diseases in more than nine thousand men at the Army Air Forces Technical Training School, Truax Field, Madison, Wisconsin. This study was conducted as a part of the Army Air Forces Rheumatic Fever Control Program.

METHODS OF STUDY

Two methods of study were used. The first consisted in the administration of 3 grams of sulfadiazine in a single dose, once weekly for eleven weeks, to a group of 140 students. Two control groups were used: first, the remainder of the squadron of the treated group, both students and permanent party personnel, approximately 700 men; and second, a group of 130 students attending the same classes as the control group but attached to another squadron.

FIGURE I



Hospital admissions for acute infectious diseases in two groups of soldiers, one group receiving three grams of sulfadiazine in a single dose weekly from January 17, 1944, to March 27, 1944. Treated group: clear bar; control group: shaded bar.

The second method consisted in the daily administration of 1 gram of sulfadiazine to a group of more than six thousand men, comprising several squadrons, for twenty-one days. Ten days after the first group was started on therapy, a second group of more than three thousand men was started and continued for twenty-one days on the same dosage. All hospital and sick call admissions for acute infectious diseases for both groups were charted, beginning two weeks before the administration of

* From the AAF Rheumatic Fever Control Program.

¹ Buchbinder, L.: Transmission of Certain Infections of Respiratory Origin, *J.A.M.A.* **118**:718-730, (February 28) 1942.

² Thomas, J. C.: Reduction of Dust-borne Bacteria by Oiling Floors, *Lancet* **2**:123-127, 1940.

³ Van den Ende, M.; Lush, D., and Edward, D. G. F.: Reduction of Dust-borne Bacteria by Treating Floors, *Lancet* **2**:133-134, 1940.

⁴ Feldt, R. H.: Sulfanilamide as a Prophylactic Measure in Recurrent Rheumatic Infection, *Am. J. Medical Sciences* **207**:483-488, (April) 1944.

⁵ Thomas, Caroline B.; France, Richard, and Reichsman, Franjo: The Prophylactic Use of Sulfanilamide in Patients Susceptible to Rheumatic Fever, *J.A.M.A.* **116**:551-560, (February 15) 1941.

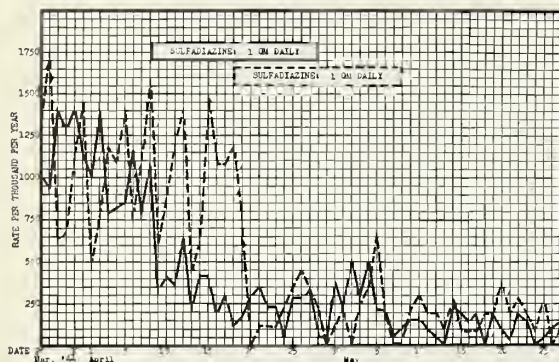
⁶ Watson, Robert F.; Schwentker, Francis F.; Fetherston, J. E., and Rothbard, Sidney: Sulfadiazine Prophylaxis in an Epidemic of Scarlet Fever, *J.A.M.A.* **122**:730-734, (July 10) 1943.

⁷ Cheever, F. S.; Breese, B. B., and Upham, H. C.: The Treatment of Meningococcus Carriers with Sulfadiazine, *Annals of Internal Medicine* **19**:602-608, (October) 1943.

⁸ Jones, Maurice: Sulfathiazole Prophylaxis of Gonorrhea and Chancroid, *U. S. Nav. M. Bull.* **40**:113-115, (January) 1942.

⁹ Gooch, James O., and Gorley, Alvin L.: The Use of Sulfathiazole as a Prophylactic Agent, *Military Surgeon* **94**:339-344, (June) 1944.

FIGURE II



Hospital admissions for acute infectious diseases in two groups of soldiers receiving one gram of sulfadiazine daily for twenty-one days. Boxes indicate periods of sulfadiazine administration. Large group: solid line; small group: broken line.

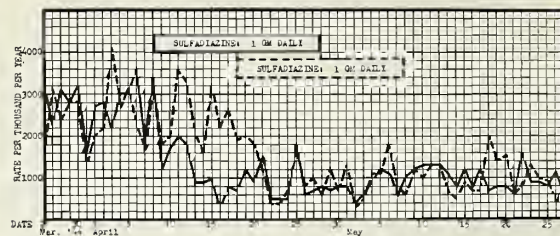
the sulfadiazine and continuing for three weeks after the second group had received their last dose. Careful records were kept of the occurrence of specific diseases and also the frequency of toxic reactions to the drug. (Figures II and III are plotted in terms of the incidence per thousand men per year.)

DESCRIPTION OF RESULTS OF STUDIES

We will first discuss the results of the administration of 3 grams of sulfadiazine once weekly for eleven weeks. This study extended from January 17 to March 27, 1944. We were unable to determine any definite effect on the disease incidence of the treated group. All three groups showed rather wide fluctuations. Figure I shows the hospital admissions for acute infectious diseases of the treated group and the small control group. We encountered only nine soldiers who showed toxic reactions to sulfadiazine, and none of them was serious—all were either febrile or cutaneous reactions, or both. An interesting observation in the treated group was that these soldiers responded to adequate dosage of sulfadiazine when admitted to the hospital with pneumonia or other illness requiring such medication. This was true even if they had been taking sulfadiazine weekly for six to eight weeks. There was no obvious difference in the response between those who had had the drug prophylactically and those who had not.

The results with the second method of administration, in contrast to the inconclusive findings in the weekly method of prophylaxis, were very marked. In this second study, one group received

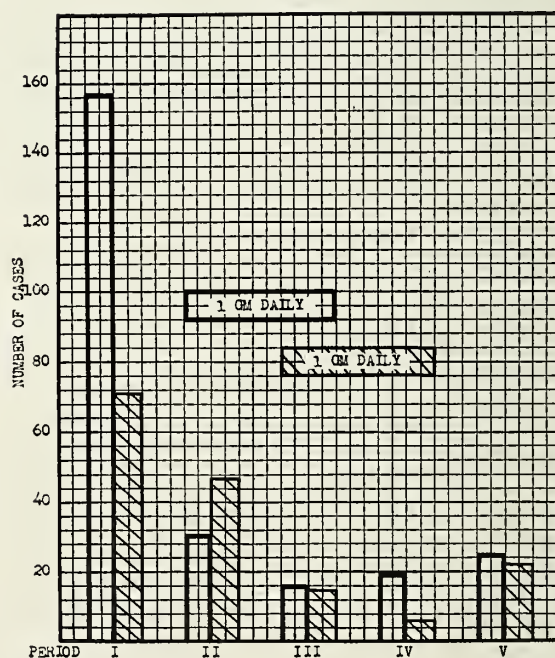
FIGURE III



Outpatient dispensary visits for acute infectious diseases in two groups of soldiers receiving one gram of sulfadiazine daily for twenty-one days. Boxes indicate periods of sulfadiazine administration. Large group: solid lines; small group: broken line.

1 gram of sulfadiazine daily from April 8 to 28, and a smaller group from April 18 to May 8. Figure II shows the effect of this method of prophylaxis. Table I shows the average daily hospital and dispensary admissions before, during, and following sulfadiazine administration. There is a marked and almost immediate drop in the hospital admissions for acute illness in both groups on the administration of the sulfadiazine. Hospital admissions show a reduction of 72.5 per cent in the larger and 77.3 per cent in the smaller group, and this diminished incidence continues at the same level even after the sulfadiazine is stopped. The smaller control group did not receive sulfadiazine until ten days after the original group had been started. During this period they continued to show a high rate of

FIGURE IV



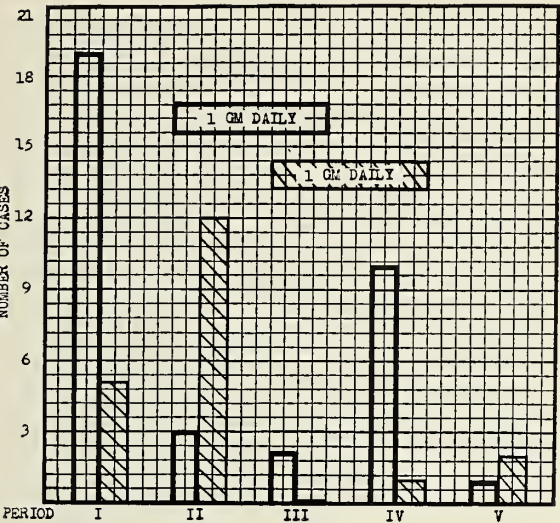
Hospital admissions for acute nasopharyngitis. Boxes indicate periods of sulfadiazine administration. Large group: clear bar; small group: shaded bar. (Period I—March 26-April 8; Period II—April 9-18; Period III—April 19-28; Period IV—April 29-May 8; Period V—May 9-27.)

TABLE I

Average Daily Hospital and Dispensary Admissions Before, During, and After Sulfadiazine Administration, One Gram Daily for Twenty-one Days

	BEFORE		DURING		AFTER	
	Hosp.	Disp.	Hosp.	Disp.	Hosp.	Disp.
Large group	16.78	43.64	4.61	16.86	4.00	18.07
Small group	8.57	19.85	1.95	8.66	2.07	11.28

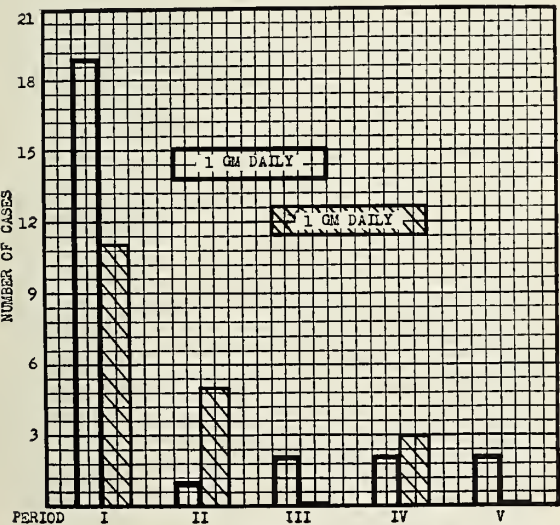
FIGURE V



Hospital admissions for acute nasopharyngitis due to beta hemolytic streptococcus. Boxes indicate periods of sulfadiazine administration. Large group: clear bar; small group: shaded bar. (Period I—March 26-April 8; Period II—April 9-18; Period III—April 19-28; Period IV—April 29-May 8; Period V—May 9-27.)

illness with a marked immediate drop on administration of the drug. This is further indication that the diminished disease rate was not fortuitous. Figure III shows the effect on the sick call in the outpatient dispensaries. Here again the sudden and immediate drop in illness is evident following administration of the drug. The data in Figure III include not only those soldiers who were admitted to the hospital because of the severity of their

FIGURE VI



Hospital admissions for scarlet fever. Boxes indicate periods of sulfadiazine administration. Large group: clear bar; small group: shaded bar. (Period I—March 26-April 8; Period II—April 9-18; Period III—April 19-28; Period IV—April 29-May 8; Period V—May 9-27.)

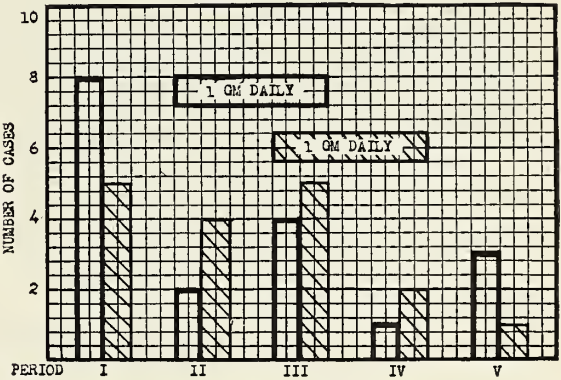
illness but also those with minor respiratory infections, usually afebrile, who could be treated while remaining on duty.

We have further studied the effect on several specific diseases. Figure IV shows the effect on acute catarrhal nasopharyngitis. Here again the data show the definite drop in the rate while on sulfadiazine prophylaxis and the continued effect even after cessation of the treatment. Figure V shows the effect in acute catarrhal nasopharyngitis where the causative organism was proved by culture to be beta hemolytic streptococcus. Here, as would be expected, the effect is even more dramatic and the prolonged effect is again evident.

At the time the study was started at this field we were having a high rate of scarlet fever. Figure VI shows the effect on scarlet fever. Again a marked drop in the disease rate is evident on administration of the drug. However, in the fourth period the smaller group, then on treatment, shows an unexplained increase over the previous period.

Figure VII shows the effect on the incidence of primary atypical pneumonia. The Army has had considerable experience with this disease and the consensus of opinion is that sulfonamides are of

FIGURE VII



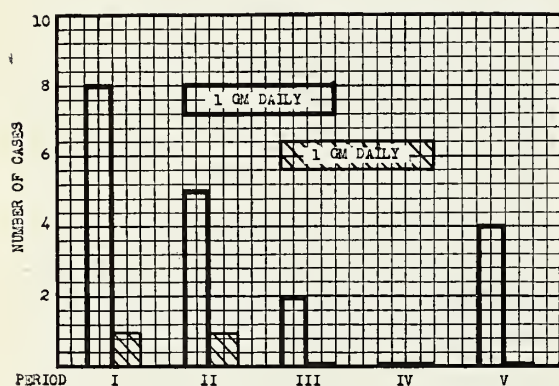
Hospital admissions for primary atypical pneumonia. Boxes indicate periods of sulfadiazine administration. Large group: clear bar; small group: shaded bar. (Period I—March 26-April 8; Period II—April 9-18; Period III—April 19-28; Period IV—April 29-May 8; Period V—May 9-27.)

little value in the treatment. The etiology is unknown although a virus has been suspected. While there is some evidence of a diminution in the incidence, it is not marked and probably not outside the normal fluctuations expected in a group of this size. This is the result one would expect from the present knowledge of this disease. Mumps and measles, two diseases of probable virus etiology, also showed no decrease in incidence under sulfadiazine prophylaxis.

Figure VIII shows the effect on acute rheumatic fever. It will be noted that in this disease the effect is delayed. No definite effect is apparent until the third period when one group had had the drug for ten days and the smaller group started therapy. The most definite effect is apparent in Period IV

when the first group had stopped the drug and the smaller group had had the drug for ten days. At no time did the incidence approach that of the first two periods. These results fit in well with the present concept of the relationship of beta hemolytic streptococci to rheumatic fever. Coburn¹⁰ believes that rheumatic fever is preceded by infection with beta hemolytic streptococci. After this infection there is a quiescent period of from a few days to six or seven weeks during which time there is little or no evidence of disease. Then acute rheumatic fever appears. During this period of rheumatic fever there may be no evidence even by cultural methods of the presence of beta hemolytic streptococci. The disease is in effect an immunological reaction to streptococcal infection, according to this theory.

FIGURE VIII



Hospital admissions for acute rheumatic fever. Boxes indicate periods of sulfadiazine administration. Large group: clear bar; small group: shaded bar. (Period I—March 26-April 8; Period II—April 9-18; Period III—April 19-28; Period IV—April 29-May 8; Period V—May 9-27.)

The incidence of reaction to sulfadiazine among these nine thousand men taking 1 gram of the drug daily for three weeks is remarkably low. The total number of reactions is thirty-four—0.37 per cent. None of these reactions was of a serious character. One officer had a moderately severe angioneurotic edema which subsided without difficulty. Most of the reactions were mild and caused no loss of time from duty. One difficulty encountered, and one which accounted for hospital admission in several cases, was the differential diagnosis between drug reaction and an acute exanthem, usually measles or scarlet fever. Every care was taken to establish an accurate diagnosis, the cases being examined by both the dermatologist and the contagious disease officer before a diagnosis was established.

DISCUSSION

This study indicates that sulfadiazine can effectively control an outbreak of acute infectious dis-

ease if given in proper dosage. It is evident that a dosage of 3 grams given once weekly is not an adequate method of control. However, 1 gram of sulfadiazine given daily over a prolonged period will serve to control the outbreak.

The results are even more striking when it is known that there was a large number of men on the post who were not included in the two groups studied. These men could have acted as a focus to infect the groups under study. As a matter of fact, we have figures which suggest that the marked drop in the incidence of illness in the study groups served to reduce the incidence of disease among the untreated men as well.

There can be little question that sulfadiazine given daily was effective in reducing the disease rate in both groups. The larger group of six thousand men was given the drug for ten days before the second group was started. During this period the disease rate remained elevated for this untreated group. However, when they were placed on treatment, they, too, showed the same marked and immediate drop in hospital admissions. Both groups then continued to show a reduced incidence for three and four weeks after the cessation of treatment. There was a reduction of approximately 75 per cent in the number of hospital admissions both during the period of treatment and for two weeks after it was stopped.

The number of men reporting to the outpatient department for respiratory complaints was also much reduced in both groups, and the curves followed the same general pattern as for hospital admissions. This is not surprising as most of these complaints were probably due to the same type of organism causing the more serious illnesses.

The most marked effect was shown in those diseases caused by or associated with beta hemolytic streptococci. Scarlet fever and nasopharyngitis caused by beta hemolytic streptococci showed a dramatic response. The drop in the disease rate was such that we were able to close one scarlet fever ward. The incidence of simple upper respiratory infection—acute catarrhal nasopharyngitis—also showed the same fall. This is to be expected as many of these infections are caused by streptococci or other organisms susceptible to sulfonamide therapy.

These results are in accord with those of others who have reported on the decreased incidence of streptococcal respiratory infections in rheumatic fever subjects on sulfanilamide prophylaxis.^{4, 5} Our experience in this study with the reduced incidence of rheumatic fever—a delayed effect—shows the possibilities in preventing such disabling complications of streptococcal infections. One might also point out the probability of a similar effect on the incidence of glomerulonephritis in such a prophylactic program.

There are three serious objections to the use of a sulfonamide prophylactically, as carried out in this program. The first is the danger of serious toxic

¹⁰ Coburn, Alvin F.: Epidemiology of Streptococcus Hemolyticus Infections at Naval Training Stations, I, *U. S. Nav. M. Bull.* 41:1012-1018, (July) 1943.

reactions to the drug. We experienced no serious reaction with either dosage program. While extensive investigations were not carried out to determine the effect on the kidneys or bone marrow, no evidence was encountered that would indicate any toxic effect on these organs. It is generally agreed that sulfadiazine is the least toxic of any of the sulfonamides, and our experience confirms that opinion. Our incidence of toxic effects is less than that reported by any of the investigations using sulfanilamide in the prophylaxis of rheumatic fever.^{4, 5}

The second objection to such a prophylactic program is the danger of sensitizing a large number of people to the drug, so that it cannot be used when a serious infection occurs at a later date. This is a very valid objection. However, we did not encounter any difficulty in giving the drug to any of these soldiers who were admitted to the hospital with conditions requiring such medication.

The third objection to this program is the possibility of producing sulfonamide-resistant organisms as a future problem. This is largely speculative at this time.

This successful demonstration of mass chemoprophylaxis to control the incidence of infectious diseases raises the question as to when it should be employed. Certainly it should not replace the other hygienic measures usually used. The disadvantages appear to be relatively minimal, especially if sulfadiazine is used. It must also be pointed out that a smaller dosage schedule might work equally as well. The minimum amount and frequency of administration have yet to be worked out. It is evident from our data that such prophylaxis is most effective in reducing the incidence of diseases due to streptococci. At the present time it does not seem wise to advise such means to control endemic conditions in a normal civilian population.

The conditions peculiar to army life during time of war are such as to encourage the rapid spread of streptococcal respiratory infections. These conditions normally do not exist to such an extent among a civilian population. It would seem, however, that under certain conditions, in prisons or

children's or old people's institutions, such a method would prevent serious epidemics with the severe complications which follow streptococcal infections. Watson, *et al*,⁶ have pointed out that one criterion for the use of sulfonamide prophylaxis in such situations should be the occurrence of a predominant type of streptococci among the inhabitants. The application of the modern technics for grouping and typing streptococci will determine when this situation is present. When a large number of the patients are harboring streptococci of the same type with strongly invasive capacity, the danger of a widespread epidemic of severe illness is great and a prophylactic program is indicated. Due to lack of proper facilities we were unable to type the streptococci isolated from our patients, but our data does confirm the prompt effect on streptococcal diseases.

CONCLUSIONS

1. Sulfadiazine in a prophylactic dosage of 3 grams once weekly proved ineffective in reducing the incidence of acute infectious disease among a group of 140 soldiers.
2. Sulfadiazine in prophylactic doses of 1 gram daily effectively reduced the incidence of certain acute infectious diseases among nine thousand soldiers.
3. This effect was evident both on admissions to the outpatient department and on hospital admissions for acute infectious diseases.
4. The most marked effect was on those diseases caused by beta hemolytic streptococci, scarlet fever, and nasopharyngitis due to streptococci.
5. A definite effect was also apparent on the incidence of rheumatic fever, occurring at a later period than the effect on acute hemolytic streptococcal disease.
6. There was no effect on those diseases caused by virus infection or of unknown etiology under this method of prophylaxis.
7. Among nine thousand men, only thirty-four toxic reactions were encountered and none of them was serious.



*If the Axis uses gas, AAF medical personnel
will be ready for any emergency.*

LOW BACK PAIN*

CAPTAIN JAMES VERNON LUCK, M.C.

SANTA ANA, CALIFORNIA

In our trek toward a clear understanding of low back pain, several significant milestones have been passed in recent years. Most important, perhaps, has been the recognition of intervertebral disc changes as the cause of several low back disorders. Important also has been the discovery that lesions in such soft tissues as ligaments, aponeuroses, joint capsules and bursae possess the capacity for transmitting far-reaching pain radiations. With this better understanding of diagnosis has come a clearer concept of therapy. The identification of several new and clear-cut syndromes amongst the low back disorders has not simplified this already complex field, but has enabled us to allocate more accurately the sources of pain and has helped us depart from the use of such unscientific but familiar diagnostic terms as sciatica, low back strain, and sacro-iliac dislocation.

In the army the diagnosis and treatment of low back pain in enlisted men resembles the problem seen in industrial surgery. In treating aviation cadets and aviation students we deal with men who count the days and hours until they can be back on full duty with their squadrons. We must often restrain them to prevent overexertion during their convalescence. We must examine them and quiz them diligently to prevent underestimating the severity of their condition. Their malingering is virtually all on the side of covering up present and past illnesses rather than feigning non-existent conditions. Of course, there have been a few exceptions and psychoneurosis among cadets has not been uncommon.

Every effort is exerted to make an accurate diagnosis. This is not always possible, but we feel that we have been successful in the majority of cases. Efforts spent to identify the lesion, or at least the tissue in which the lesion exists, has greatly facilitated both therapy and the proper disposition of the case.

A simple working classification, shorn of rare entities which have little practical significance, is employed to good advantage. Incomplete as this classification may be, it has simplicity in its favor and it invites more systematic examination and diagnosis than do some of the more complex classifications. The various orthopedic entities, both clinical and pathological, encountered in the low back are classified as follows:

1. Arthrogenic syndromes:
 - a. Periarticular (Ligamentous).
 - b. Intra-articular.

2. Myogenic syndromes:
 - a. Traumatic.
 - b. Inflammatory.
3. Neurogenic syndromes:
 - a. Impingement.
 - b. Inflammatory.
4. Psychogenic syndromes:
 - a. Acute.
 - b. Chronic.

ARTHROGENIC SYNDROMES

Periarticular

As would be anticipated, acute traumatic ligament injuries have been the most frequently encountered lesions and have responded to diagnostic and therapeutic measures in about the same manner as similar sprains and strains elsewhere. The vast majority of these ligamentous and aponeuro-ligamentous lesions, for anatomical and mechanical reasons, are located on the dorsal aspect of the low back, are accessible to palpation, and are usually manifest by circumscribed or "trigger point" tenderness. Experience has indicated that there are several well-defined points in the low back where these lesions can be expected to occur. They are the lateral and medial aspects of the posterior superior iliac spine, the junction of posterior and middle one-third of the iliac crest, the spinous processes of the fourth and fifth lumbar vertebrae and first sacral segments, the fifth lumbar transverse processes and the lumbo-sacral joints. Anatomical dissections give a clue to the susceptibility of these several points to acute strain. At the lateral aspect of the posterior superior and inferior iliac spine, a portion of the fascia lata enclosing the gluteus maximus muscle fuses to the long posterior sacro-iliac ligament and the resulting conjoined structure enters the iliac cortex. The anchoring fibers of Sharpey thereby fall heir to the stresses exerted by both the muscle and the ligament.

On the medial aspect of the posterior superior and inferior iliac spines a similar anatomical construction results from a conjoined attachment to the ilium of a part of the short posterior sacro-iliac ligaments and a part of the aponeurosis of the powerful sacrospinalis muscle. The sacrospinalis muscle also attaches to the lumbar supraspinous and interspinous ligaments. During heavy lifting and other types of exertion which subject the low back to mechanical strain, the force exerted at the above-mentioned points is tremendous. During lifting, with the spine bent forward, a force ten or more times the weight of the object lifted is developed in the lower part of the back. It is remark-

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able that the incidence of traumatic strains and tears of supporting tissues of the low back is so low.

At least half of the cases exhibiting circumscribed tenderness in the low back are associated at some time in their course with radiating pain in one or both lower extremities. This radiating pain, which is usually down the posterior aspect of the thigh and leg, has been the cause of much confusion. Investigators searched for a nerve root or nerve trunk lesion to accompany the dorsal soft tissue lesion so they could explain both the radiating pain and the low back pain.

Several years ago it was my privilege to collaborate with Dr. Arthur Steindler in a study of the soft tissue lesions associated with low back pain.¹ As a part of this study a procaine hydrochloride solution was injected into sites of point tenderness over ligaments, fasciae, and muscles. While inserting the needle the radiating pain was unexpectedly reproduced and accentuated. Following this observation we probed the site of tenderness with the needle point in several hundred cases in order to strike the lesion and accentuate the radiating pain. Two to ten cc's of 2 per cent procaine hydrochloride were injected. In approximately seventy per cent of the cases injected the radiations were reproduced, the local pain accentuated by the needle point; then following the injection of procaine hydrochloride, all radiating and local pain was relieved and leg signs became negative for at least as long as the procaine hydrochloride anesthetized the lesion. This was considered to be a positive test and is believed to indicate that the superficial soft tissue lesion was responsible for both the local pain and the radiating pain. It is certain that the needle point contacted no nerve roots or trunks, only the nerve supply to the ligament, aponeurosis or muscle at the site of the lesion. Thus, we no longer need to search for a second lesion involving a nerve trunk or root to explain the radiations when there is a positive procaine test.

The radiating pain from a soft tissue lesion is different in several respects from pain radiations due to an impingement or inflammation of a nerve. Radiating pain from the soft tissue lesions described resembles a reflex and has been termed reflex radiations; whereas, the radiating pain associated with a diseased or impinged nerve is referred along that nerve and will be called referred radiations. Reflex radiations are characterized by poorly-defined and inconstant patterns of distribution, and they are not associated with motor, sensory, trophic or tendon reflex changes. There is no nerve trunk tenderness and little muscular atrophy. There is evidence that the more acute and severe the local pain, the more extensive the distribution of the reflex radiations. Usually such radiations extend no farther distally than the popliteal region, but it is not uncommon, especially

in acute phases, to find them extending into the foot. In contrast to these characteristics, referred radiations usually have a well-demarcated consistent pattern of distribution and may be associated with reflex, sensory, motor, and trophic changes. In inflammatory nerve lesions there is usually nerve-trunk tenderness. Pronounced muscle atrophy is not uncommon, and there may be no position of relief. The most frequent source of referred pain amongst low back lesions is nerve root impingement from protrusions of the nucleus pulposus.

If our contentions regarding reflex radiations from soft tissue lesions are factual, such radiations should be found elsewhere in the body; they may be seen extending from the elbow to the fingers in tennis elbow. We have consistently been able to accentuate these radiations with a needle and relieve them with procaine hydrochloride. A similar situation occurs in supraspinatus calcification and subdeltoid bursitis, where a positive procaine test is the rule. Other sites where positive tests have been observed are the acromioclavicular ligaments, subgluteal bursa and trochanteric bursa.

Procaine hydrochloride injections are useful as a therapeutic measure and may be repeated as often as daily. Deep point massage for about five minutes is used directly after the injection. The prognosis has been found to be good when a procaine test is positive. Response to conventional forms of conservative treatment can be expected in the vast majority of cases. Focal infections appear to have caused a protraction of symptoms in some cases. Elimination of focal infection has been occasionally associated with dramatic relief of the low back symptoms.

Another important anatomical factor responsible for the susceptibility of many individuals to low back strains is observed in the form of congenital defects of the lumbosacral and sacro-iliac ligamentous apparatus. Osseous defects, such as spina bifida, lumbosacral tropism and transitional fifth lumbar transverse processes, are associated with defective construction of their associated complex ligamentous architecture. For example, a bifurcation of the upper sacral segments would likely be of little significance if there were not a similar defect in the short posterior sacro-iliac ligaments. The abnormal ligamentous arrangement with unilateral transitional fifth lumbar transverse processes is obvious.

Intra-articular (arthritides)

Intra-articular involvement of the lumbar and sacral joints has been encountered in a substantial percentage of our cases. In this field excellent cooperation from our x-ray department has been of inestimable value to us. With these entities we are supported by more evidence of the character of the pathology of the pain-producing lesions than we are when dealing with the soft tissue lesions. Although there are many arthritides, the ones that are of most concern to us are, in the order named,

¹Steindler, Arthur, and Luck, J. V.: Differential Diagnosis of Pain Low in the Back, *J.A.M.A.*, **110**:106, (Jan. 8) 1938.

degenerative or hypertrophic arthritis, proliferative or atrophic arthritis, and tuberculous spondylitis.

Degenerative Arthritis

Most common of all joint changes are degenerative changes and the responses they call forth. The precipitating causes for these changes are legion, but the most important single etiological factor is trauma. There is much to support Pommer's explanation of the pathogenesis (the functional theory), in which he describes the initial change as loss of elasticity and degeneration of the articular cartilage. All other changes, such as the reactivation of enchondral ossification forming marginal exostoses, the subchondral sclerosis, and the wearing away of the articular cartilage, are physiological responses and adapt the joint to continued function. These changes are dependent upon continued function of the joint for their evolution.

Trauma as the great etiological agent in hypertrophic arthritis must be defined in the broadest terms and must include micro-traumata. Lumbar and sacral joints that are abnormally aligned or present a congenitally-defective mechanical construction are subjected to micro-traumata throughout their viable existence. Such joints vary widely in their response, both as regards their clinical manifestations and their pathological alterations. The margin of security in the low back is wide during youth by virtue of good musculature, rapid healing responses, and a sturdy elastic ligamentous apparatus. With advancing years (beginning usually in the twenties and thirties), the supporting structures steadily become less able to absorb or transmit the stresses to which they are subjected.

In a high percentage of patients presenting complaints of pain in the low back, anatomical anomalies are observed, and these anomalies set the stage for degenerative arthritis in low back joints. The incidence of such anomalies is higher among individuals with back pain, inferring that these abnormalities impair the normal function of the spine. The construction of the fifth lumbar vertebra and sacrum are of particular significance; we are concerned about the construction and alignment of the lumbosacral facets. They vary through such a wide range that we wonder what could be termed as normal. But a tropism, which is alignment of the two pairs of facets in planes at right angles to each other, unquestionably presents a mechanical problem in which one of these two joints is subjected to a strain with every full-range movement of the lumbar spine. Degenerative changes developing in such joints in early adult life is common and ordinarily develop first in the joint in or nearest the frontal plane.

The angle formed by the junction of the sacrum and lumbar spine, the lumbosacral angle, varies from only a few degrees to a right angle. The great shearing stresses imposed upon the lumbo-sacral ligaments in the presence of an acute lumbosacral angle are at once appreciated. Our efforts, in

therapy, to flatten the lumbar lordosis and diminish this angle as much as possible have a sound basis in mechanics and in clinical results. Our postural exercises, belts, braces, and casts have an important place here. Lumbar casts have served us well. They are applied with the spine flexed a little forward to flatten the lumbar region, have little padding, and are moulded well over the sacrum.

Another congenital defect which we have observed rather frequently has been a transverse interruption in bony continuity at the isthmus between superior and inferior facets of the fifth lumbar vertebra, and occasionally the fourth lumbar. We have seldom seen the defect without some resulting forward slipping of the superimposed spine; that is, we have seen spondylolisthesis far more frequently than spondylolysis. When there have been persistent disabling symptoms, we have usually recommended that the soldier be discharged from the Army. In all but one case the period of Army service has been short. In that one instance the patient had been in the Army nine years, so we did a lumbosacral fusion.

Bilateral transitional fifth lumbar transverse processes that do not articulate with or impinge on the ilium or sacrum probably cause little trouble, but when there is a transverso-sacral or transverso-iliac joint, the joint is anomalous and poorly constructed. Degenerative changes and clinical symptoms occur in a high percentage of these cases.

Spina bifida of the upper sacral segments and the fifth lumbar vertebrae are among the most frequent low back anomalies we have observed. When they are small and represent merely a cleft they seldom have clinical significance, but when the defects are large there is a sound basis for believing that they predispose to low back pain. A separate neural arch of the fifth lumbar vertebra has been seen occasionally, not uncommonly in conjunction with spondylolisthesis. It seems definitely capable of causing trouble.

It has been pointed out that anomalies of the low back are seen every day in x-ray films taken for other purposes than orthopedic problems, for example, genito-urinary. This fact had led some observers to the false conclusion that such anomalies are of no clinical significance. Symptoms do not develop in all cases but follow such anomalies through the years, and if the patient uses his back for heavy work it will ache sooner or later. Strains of the back, and in fact of any articulation, appear to be cumulative. For example, a patient may exert himself daily beyond the normal endurance of his back for a considerable time and have no clinical symptoms beyond a slight aching; then while doing the same chore he has performed for days he will suddenly develop acute pain in his low back and have days or weeks of disability. Such individuals need instructions in regard to protecting their backs and must learn to recognize warning signals. Many soldiers, not knowing how to lift, bend their spine straight forward and develop tremendous shearing stresses in the low back. Keeping the back

vertical and lifting with the legs cannot be over-emphasized when dealing with men and women doing heavy lifting.

Degenerative arthritis of the sacro-iliac joint occurs rather frequently but in only a small percentage of cases as compared to similar lumbosacral changes. Anomalies of the sacro-iliac joints are rare and have little practical importance. Most of the degenerative changes we have observed in soldiers were the result of and superimposed upon an old burned-out rheumatoid arthritis of childhood.

Proliferative or Atrophic Arthritis

Once well developed, this entity offers little difficulty in diagnosis, but in its early acute stage it frequently is misinterpreted as an acute strain. The rigid spine, the widespread facet tenderness, and the high sedimentation rate all serve as signs pointing to this treacherous entity. We are seldom without at least one of these patients in the Orthopedic Section. The only joint that has shown early changes detectable in the x-ray has been the sacro-iliac joint. The irregular articular cortices and subchondral mottling are fairly typical. These patients are referred to the Medical Service for a thorough diagnostic and therapeutic regime.

Tuberculous spondylitis is occasionally observed in soldiers, but we have not observed a single case here at the Santa Ana Army Air Base. We do tuberculin tests (1 to 10,000 up to 1 to 100) whenever there is a question of tuberculosis. Repeated roentgenograms are indispensable in the diagnosis of this entity. It is outside the scope of this paper to include further details of intra-articular lesions.

MYOGENIC SYNDROMES

Traumatic

We have seen few cases of severe low back pain among soldiers which we felt could be attributed to muscle lesions. Of course, there are hundreds of painful backs due to muscle soreness after physical exertion, but these cases do not usually consult a physician. However, we have had an occasional case of contusion to the back musculature—some of them rather severe. These have come principally from the athletic fields and resulted from knees striking the back or from falls over sharp objects. These cases have responded well to massive hot packs.

Inflammatory

So-called "myositis" or "myofascitis" has not been one of our problems; at least we have not recognized it as such. In the past year we have not seen a single case of low back pain which we have believed to be primarily an inflammation of the spinal muscles. It is our opinion that most cases diagnosed as myositis are, in reality, arthrogenic syndromes.

NEUROGENIC SYNDROMES

Impingement

Low back pain on the basis of nerve root impingement is very often associated with posterior

protrusion of the nucleus pulposus through the annulus fibrosis of the intervertebral disc. This entity so much discussed in recent years is now well established. Since treatment of these cases is principally in the realm of neurosurgery, only a brief description of this entity will be herewith included.

There are no pathognomonic signs or symptoms of these lesions, but on the basis of the entire clinical picture a diagnosis can be made in the majority of cases without resorting to myelograms. So called "sciatica" or "sciatic radiation" is the most disabling symptom. As already described, these radiations are the referred type and must be differentiated from reflex radiations that emanate from lesions in ligaments, muscles, or joint capsules. The referred radiations associated with impingement of a lower lumbar nerve root have a consistent distribution usually extending distal to the knee and directed along the posterior or lateral aspect of the extremity.

Pains radiating into the buttock, thigh, leg, and foot are the source of most of the patient's distress. Only occasionally is there coexistent low back pain which causes as much distress as the radiating pain. When there is an associated severe low back pain, it is well to look for an arthrogenic syndrome as well as the root impingement syndrome.

Accentuation of the pain by coughing or sneezing is a prominent symptom of a nerve root compression, but this symptom also appears in both intra-articular and extra-articular arthrogenic lesions.

A history of trauma to the low back is the rule, and it results from a fall, a jump, or from heavy lifting.

A history of exacerbations and remissions characterizes most cases. This is an important feature of the history of the majority of cases that have been treated surgically. How best to explain the remissions is not clear, but it is claimed that the protruding disc may spontaneously reduce itself only to reappear later. Another explanation could be that edema of an inflammatory element produces impingement at the site of a minor protrusion of the disc. During periods of quiescence of the inflammation there may be sufficient space for the nerve root.

Lower lumbar nerve-root impingement is frequently associated with a diminution or absence of the Achilles reflex. This is a helpful diagnostic sign, but is by no means pathognomonic. Most important of the leg signs is the straight leg-raising test, which is nearly always positive. During many acute phases the straightened leg can be raised only ten or fifteen degrees.

The so-called "sciatic scoliosis" that so regularly characterizes this entity results from lateral deviation of the lumbar spine away from the side on which the lesion is located. Compensation of the lumbar deviation in the dorsal spine completes the scoliotic curvature. In less conspicuous sciatic

scolioses, bending the spine laterally to each side is helpful to identify the lumbar deviation. When the lateral bend is to the side of the lesion it is sharply limited in the lumbar region compared to the free lateral bend away from the side of the impingement. Forward bending only partially dispels the lumbar inclination.

Tenderness of the sciatic trunk is usually absent, but may occasionally appear to a mild or moderate degree. Pronounced sciatic trunk tenderness is more likely to portray a sciatic neuritis; that is, an inflammatory lesion of the trunk rather than a root impingement. Occasionally the two entities are found together.

A positive Queckenstedt test and an increase in the total protein content of the spinal fluid above 50 mg. per 100 cc. are important findings, but the diagnosis of a spinal root impingement syndrome does not demand that any diagnostic test or sign, taken alone, be positive.

Orthopedists have welcomed the swing to conservatism in the resection of the posterior spinal arches. It is not generally admitted by some surgeons, but many are the cases that subsequently had to have spinal fusions because of the disability consequent to wide spinal explorations.

There is disagreement as to when a spinal fusion should accompany a lower lumbar spinal exploration. Neurosurgeons, as a group, see fewer indications than orthopedists. At the New York Orthopedic Hospital nearly every lumbar exploration is accompanied by a spinal fusion. When there are symptom-producing lumbosacral congenital anomalies or localized arthritic changes, a lumbosacral arthrodesis is indicated following removal of a lower lumbar herniated nucleus pulposus.

Inflammatory

An entity too little talked about and too little recognized is sciatic neuritis with or without lumbar radiculitis. With widespread and enthusiastic investigation of the nerve-root compression syndrome, there has been a tendency to look upon lower extremity radiating pain as due to nerve compression until disproved. The writer is familiar with several instances where cases of sciatic neuritis were needlessly subjected to spinal exploration.

The most important single symptom pointing to a sciatic neuritis is pronounced sciatic trunk tenderness. Sensory changes may or may not be present, but when found they usually appear as hyperalgesia which involves areas of distribution covering several lumbar nerves. A careful sensory check is indispensable. A lumbar radiculitis may be the source of low back pain, and it can be accurately diagnosed only by a sensory examination. The area of hyperalgesia in the low back corresponds to the distribution of the lumbar or sacral nerves involved by the inflammatory process. Ordinarily unilateral, the disease may occasionally appear bilaterally. Areas of involvement are widely variable and may be represented by a band of hyperalgesia from two or three inches wide to

involvement of the entire lumbodorsal area. A lumbar and sacral distribution is the most frequently observed, but involved areas limited to parts of the dorsal or cervical regions are common. In acute cases the hyperalgesia may be so pronounced that the patient strongly resists palpation or pin pricks in the involved area.

Therapy in the form of hot compresses often accentuates the pain; whereas, cold packs may relieve the pain. An effort should be made to eliminate focal infection. Abscessed teeth probably head the list of focal infections that appear to play a part in this entity. Vitamins B and the entire B Complex, when administered in large doses, have beneficial effects in some cases. Acute respiratory infections, when associated with the neuritides, should receive active treatment.

PSYCHOGENIC SYNDROMES

Many of the beds in military hospitals are occupied by the psychologically disabled. These psychological problems are distributed amongst every specialty in medical practice, and orthopedics is no exception. Since in the army the low back is one of the foremost sites of psychogenic manifestations, it is important to recognize this syndrome. An appalling number of cases of neurotic backaches go unrecognized and suffer through the years, tagged with such diagnoses as sacro-iliac slips, lumbosacral strains, and arthritis.

Our attitude toward these disorders has changed somewhat in the past decade and deserves to change even more. As pointed out by Weiss and English,² we must not concentrate on finding pure psychogenic disorders, but rather we should look for a psychogenic element in all of our cases. The question should be, how much of the problem is organic in character and how much is functional? Menninger has stated that "every surgical patient has a psychological aspect to his illness." There is, of course, a large group of psychogenic cases in which we are unable to identify an organic lesion.

A psychological history should be taken routinely in all cases of chronic low back pain and in some acute cases. Cases which by superficial examination appear of organic origin may prove later to be psychogenic in character. Many of these cases may possess an acute arthrogenic lesion at the outset, which soon heals only to have many of the symptoms perpetuated via a neurosis kindled by the acute illness. In conversion hysteria an episode of neurotic physical symptoms may follow a period of great emotional stress.

Psychogenic Back Symptoms

In that the following symptoms are much more frequently associated with mental ailments than with organic lesions, they may be considered to be of psychological origin until proved otherwise: stammering, enuresis in older children and adults,

² Weiss, E., and English, O. S.: *Psychosomatic Medicine*, W. B. Saunders Co., Philadelphia, 1943.

insomnia, night terrors, palpitation of the heart, emotional instability, tics, globus hystericus, nervous breakdown, nail-biting, certain types of vertigo, headaches, sexual impotence, and fainting. When one or several of these symptoms are present without an organic lesion to explain them, a thorough psychological study is in order. These symptoms, in association with low back pain, invite a serious consideration of the psychic origin of the pain. Every patient should be thoroughly examined to rule out organic lesions before a psychological diagnosis is rendered.

Family History

In the family history a search should be made for instances of emotional immaturity and instability. A mother or father who repeatedly had "nervous breakdowns" may have disrupted the personality development and created neurotic tendencies in their children.

Present History

In the present history possible environmental conflicts must be sought out. This is particularly true in the Army, since becoming a soldier usually entails profound environmental changes. A maladjustment to the new life may be associated with discontent, disappointment, disillusionment and disgust; and if these are allowed to persist, the resulting frustration with its drain on energy may precipitate mental depression which, in turn, may give way to a neurosis. Manifestations of neuroses are unpredictable, but frequently include low back pain. Low back pain may be the principal or even the only physical manifestation of a conversion or anxiety hysteria. Exacerbations and remissions are the rule, and the remissions may be brief or of many years' duration. Low back pain in neurasthenia is usually less severe, of longer duration, not so subject to remissions, and associated with several other physical symptoms involving in particular the gastro-intestinal tract.

Army life is fraught with emotional and psychical stresses, and the soldier with a poor psychical constitution is bound to accumulate frustrations which ultimately may become converted into physical manifestations. Just as some individuals have a low threshold of pain, there are individuals who have a low threshold of neurotic conversion. It is reasonable to assume that all men have a threshold of neurotic conversion, but normal individuals are capable of withstanding tremendous emotional storms before converting their mental conflict to physical symptoms.

It is in good order to review some of the elements of army life that drive the man of small emotional stature into a neurosis. Whereas regimentation stabilizes and benefits the mental health of many men, in others it generates resentment, a feeling of inferiority, loneliness, and a desire to return to home ties, but the majority adjust themselves to it. Since army routines are frequently a great physical strain, it is important that sleep be sound and

adequate. Fatigue not neutralized by sufficient sleep and relaxation begets more fatigue and sets the stage for emotional chaos. The resulting psychic stress dissipates more and more energy, disrupts sleep, and ultimately pushes the susceptible soldier into a nervous breakdown.

It is a common experience to find soldiers who have such limited endurance that they are unable to indulge in strenuous physical exertion. Psychogenic low back pain is a frequent associated symptom in these cases. The history often discloses emotional conflicts that date from childhood. Through the years these soldiers have dissipated much of their energy in the useless expression of their neurosis. These misfits are a burden to their commanding officers and the Medical Corps.

Unpleasant, strenuous, and monotonous assignments weigh heavily upon the emotionally-unstable soldier. The yardbird and the K.P. with his painful back and feet are steady customers of the dispensaries. It is a widespread practice to label most of these chronic complainers as "goldbricks" and order them back to duty. Such a practice must be condemned in most instances. It is well established that the malingerer is in the minority at most fields, the majority of the chronic complainers without organic lesions being neurotics. To treat these neurotics as malingerers only aggravates their symptoms and increases their cost and burden to the Army.

Sex problems have occasionally appeared as the most important factor in creating emotional conflicts, but these instances are in the minority in our series. Economic and social problems at home have played a part. With more fathers being drafted into the Army, this course of psychic trauma will likely increase.

Another psychological problem encountered among aviation cadets results from the cadet's failure in his studies and the realization that he is intellectually unfit to succeed in his academic requirements. Most of the neuroses based upon this factor have cleared up when the cadet was reclassified, but occasionally grew temporarily worse during the period of reclassification, especially if there were delays in assignment.

Subjective Symptoms

Reviewing the symptomatology of a large series of psychogenic backaches, several symptoms stand out conspicuously and have come to be used as diagnostic guideposts. These symptoms are as follows:

1. Pain in the region of the coccyx or sacrum and radiating up the spine to the dorsal region, neck, or top of head.
2. Absence of a position of relief or a position of pain accentuation.
3. Back pain uninfluenced by bending, lifting, or lying down.
4. Back pain either uninfluenced or aggravated by a period of days' or weeks' bed rest, or spine immobilization.

5. Pain appearing in coccyx or in wide areas of the back directly following healing of an organic low back lesion, such as an acute lumbosacral strain.

6. A sense of tingling and numbness in the spine or the extremities. Occasionally these sensations involve one-half of the body.

7. Daily variation in site or sites of pain.

8. Feeling as though part of low back were missing and out of full control.

9. Feeling of a "lump" in the low back.

10. Feeling of constant tension in the low back that cannot be relaxed or relieved. This symptom is likely to be associated with much restlessness and frequent change of position.

11. Constant throbbing in the back.

Objective Findings

Objective findings in the neuroses may be absent or may be prominent and extremely useful in arriving at a correct diagnosis. A thorough physical examination is indispensable regardless of a history that may point convincingly to a neurosis. Psychotherapy cannot cure a brain or cord tumor. In a given case one or many of the following objective findings may be encountered:

1. One of the most obvious of the objective findings is hysterical paralysis. It is far more frequently flaccid than spastic in type, and ordinarily limited to one extremity. There may be paralysis and loss of coordination when attempting to walk, but good control and no paralysis when lying in bed (astasia-abasia). Extensive paralysis involving a large part of the body is not common. Hysterical paralysis is usually bizarre and is associated with other neurotic symptoms which help in arriving at the correct diagnosis. Areas of diffuse weakness may be found, often with a coarse intention tremor.

2. Hypalgesia, circumferential and non-anatomical in distribution, occurs more frequently than is generally realized. Although in the areas of involvement there is hypesthesia and diminished response to heat and cold, the most striking change is the diminished pain sense (hypalgesia). Only rarely is there analgesia. The most accurate method of testing sensation is by the use of the pin prick. Using a sharp pin or similar instrument, the pin pricks are made quickly and firmly, every one to two inches. During this examination the patient is not asked whether the pin pricks feel sharp or dull; rather the examination is carried out up the extremities and trunk and down over the head, utilizing the flinching of the patient to identify the sharp areas. If he suddenly flinches at a certain level, the test is repeated at other aspects of the circumference. A stocking, glove, skullcap or trunk hypalgesia involves the entire circumference at the same level. Opposite parts of the body should be compared and areas of normally increased and decreased sensitivity should be known. In most individuals normal areas of increased sensitivity are the palmar surface of the

hand, the antecubital region, axilla, eyelids, lips, groins, buttocks, popliteal region and the sole of the foot. In general, the skin is less sensitive to pain below the knees and elbows than above. If hysterical hypalgesia is found, its presence should not be discussed with the patient and the temptation to mark levels with a skin pencil should be resisted. Only rarely is the patient aware of the presence of the hypalgesia, and to demonstrate it to him may only add to his anxiety. There is wide variation in the distribution of hysterical hypalgesia, and the distribution is not dependent upon the site of the physical symptoms. Involvement of all four extremities and the head is not unusual.

3. Camptocormia is an interesting condition in which there is pain in the back and, when standing, relief is obtained by bending forward. Such a forward bend may steadily increase until pronounced. This condition, uncommonly observed amongst civilians, is found relatively often in the military.

4. Tenderness: Large areas may become diffusely tender, but point tenderness is not found. However, sites of bony prominences in areas of diffuse tenderness may give a superficial appearance of being sites of point tenderness.

5. Vasomotor instability, particularly in the extremities, is common, and with it there may be hyperhidrosis and hyperactive reflexes.

6. With anxiety states, tachycardia and the facies of anxiety and apprehension may be a striking part of the picture.

7. A discussion of the other objective phenomena, such as hysterical deafness, blindness, and speech abnormalities, is outside the scope of this paper.

Objective Symptoms of Organic Low Back Lesions Compared to Findings in Neurotic Low Back Pain

1. Point tenderness is the rule in arthrogenic low back lesions. True point tenderness is not found in hysteria.

2. A rigid spine may occur from both arthrogenic lesions and hysteria, but in the former there is consistent muscle spasm, facet tenderness, and frequently laboratory and x-ray collaboration.

3. Objective symptoms in organic lesions rarely remain on an even keel for long periods; whereas, neurotic symptoms frequently do.

4. Sciatic neuritis is usually associated with pronounced sciatic nerve-trunk tenderness. Line tenderness directly over a specific anatomic structure is not characteristic of the neuroses.

5. A posture of forward flexion of the spine from an organic lesion is expected to exhibit associated localizing signs and frequent x-ray changes, and pronounced forward bending is rare. Such is not the case with camptocormia, which shows no linear or point tenderness and no positive laboratory studies.

6. Areas of diffuse tenderness in the low back may occur with radiculitis, but this entity is more

frequently unilateral than bilateral and has hyperalgesia in the distribution of involved nerves. No such localization or anatomical pattern of distribution occurs in the neuroses.

Therapy and Disposition

All complex problems in neuropsychiatric diagnosis and treatment are promptly referred to the Section of Neuropsychiatry. There is, however, a rather large group of cases whose symptoms are not deeply entrenched and whose conflict is easily identified. For this group superficial or minor psychotherapy is employed, and this simple procedure can and should be carried out by any physician.

Superficial or Minor Psychotherapy

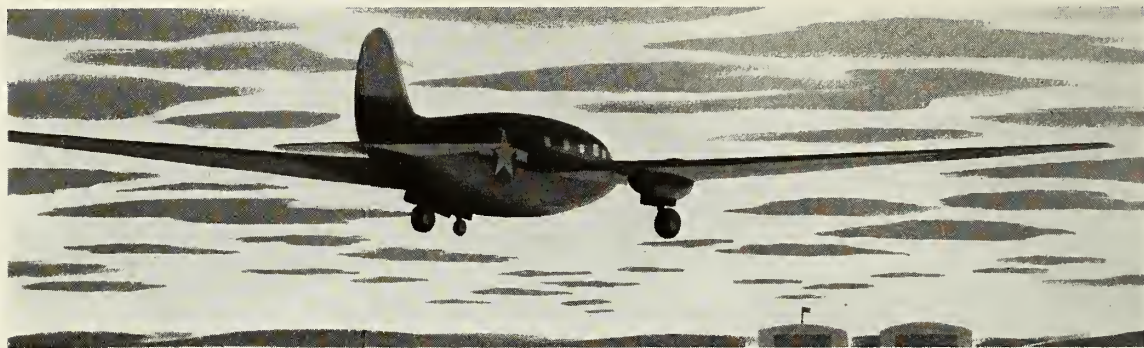
After a thorough history, physical examination, and the necessary laboratory studies to accurately evaluate or rule out an organic lesion, an estimate can be made of the proportion of the symptoms that are of psychogenic origin. After the patient's confidence is obtained, he is informed indirectly or directly of the part an emotional conflict is playing in his case. Where the conflict is environmental, as it so often is in the service, the patient is made to realize that the conflict is the source of much of his trouble and therefore must be faced, properly evaluated and, if possible, solved. It frequently has been possible to materially aid the soldier in the solution of his problem. Reclassification into a more satisfactory assignment has accomplished this in innumerable instances. Discharge from the Army has been necessary in only

a relatively small number of cases. In a much larger group the patient has been reclassified and declared unfit for overseas service. This group consists largely of soldiers having an inadequate emotional development. This group unsatisfactorily adjusts to difficult situations and is constantly on the border of converting emotional storms to physical symptoms (low threshold of conversion). To accomplish the most in psychotherapy it is essential to win the patient's complete confidence and his cooperation. Having done this, it is possible to give him lasting reassurance and a boost to his morale. The importance of being kind and considerate to these patients cannot be overestimated. An indifferent attitude and an implied or outright statement that the patient either imagines his symptoms or is a "goldbrick" usually locks the door to further assistance to the patient as far as his psychological problem is concerned. Such treatment only aggravates the symptoms and tends to fix the neurosis.

As many psychological problems as possible are treated in the dispensary. The patient is reassured, reclassified when necessary, and urged to carry on and do his job in spite of symptoms. It has been gratifying to see what a high proportion of these patients have responded to this regime. Hospitalization in the Orthopedic Section is avoided when possible. Many have been the cases that have grown steadily worse during their stay in a hospital, especially when they were erroneously diagnosed as organic in character and given intensive orthopedic therapy.



Kit, First Aid Aeronautic,
is a standard unit in
all airplanes.



A MESSAGE FROM THE AIR SURGEON

The Indiana State Medical Association is to be commended on its dedication of this issue of THE JOURNAL to the medical officers of the AAF Medical Services. Recognition of the work of these men, the majority of whom have left their civilian practice to devote their talents to the many phases of medical service of the AAF, is a gracious and fitting gesture. The high type of professional care being furnished AAF personnel throughout the world is possible only through the skill and devotion to duty of these men. Their names will be found on the honor lists, the casualty reports, and in the hearts of the officers and enlisted personnel they serve. They face the challenge presented by the new medical problems resulting from the continuing increase in speed, ceiling, range, and maneuverability of aircraft engaged in a fast-moving global conflict. They are meeting that challenge.

DAVID N. W. GRANT
Major General, United States Army
The Air Surgeon



Ninety-Fifth
Annual Session
INDIANA STATE MEDICAL ASSOCIATION
in conjunction with
ARMY AIR FORCE MEDICAL SERVICES
Indianapolis, Indiana

October 3, 4, and 5, 1944

Headquarters—Murat Temple

Complete Program on following pages



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FARMERSBURG

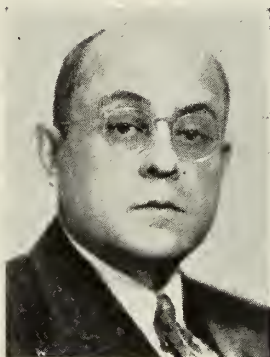
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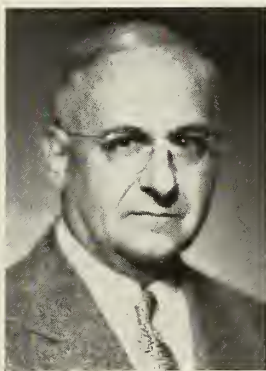
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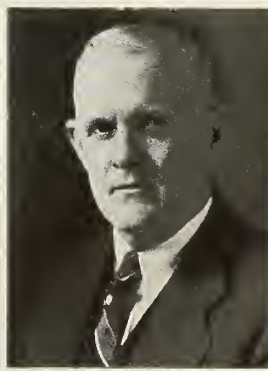
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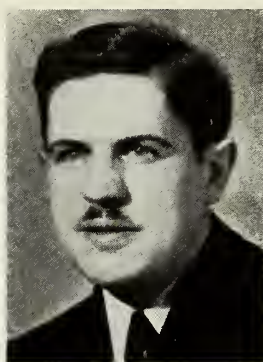
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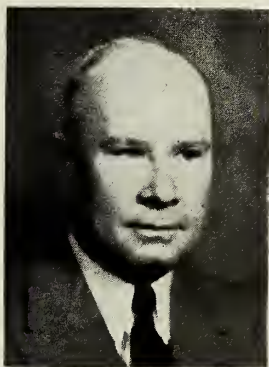
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Indiana Salutes the Army Air Forces



The ninety-fifth annual session of the Indiana State Medical Association, in Indianapolis, October 3, 4 and 5, will be held in honor of the Army Air Force Medical Services, and especially as a tribute to the hundreds of Hoosier physicians serving in the Army Air Corps throughout the world.

Led by Major General David N. W. Grant, Air Surgeon, and his staff, along with Vice-Admiral Ross T. McIntire, Surgeon General of the Navy, and Brigadier General Fred B. Rankin, of the Surgeon General's Office, the key topic of the meeting will be "Aviation Medicine."

The dedication of the coming session and this issue of *THE JOURNAL* to a special group of the armed forces follows the procedure of last year, when the meeting was held in conjunction with the Ninth Naval District and the discussions were centered around medical developments in that branch of the service. In spirit, of course, this session will be held for each and every one of the 1,260 members of the Indiana State Medical Association who are in the Army and Navy.

From pre-Pearl Harbor days Indiana has been well aware of the expanding field of the Army Air Corps in its medical as well as its military duties, as headquarters for the First Troop Carrier Command was established at Stout Field, in Indianapolis, and it is here that the original air-borne service was formed.

Colonel Ralph T. Stevenson, the surgeon at Stout Field, and his staff are cooperating with the Indiana State Medical Association in welcoming and serving as hosts for General Grant and his group during their visit to Indianapolis. Hence, the following story of the First Troop Carrier Command will bring pride to the heart of every Hoosier:



"Shoulder Litters!" instead of "Shoulder Arms!" These technicians are trained in military, medical and tactical courses, to enable them to join in evacuating wounded from combat areas, at the AAF School of Air Evacuation, Bowman Field, Kentucky.

TROOP CARRIER COMMAND

For the enemy, death! For our boys, new hope of life—it is a life and death mission the Troop Carrier Command is fulfilling in World War II.

Giant transport planes and gliders of this new branch of the Army Air Forces speed troops by air



Administration Building at Stout Field, Indianapolis, Indiana, headquarters of the First Troop Carrier Command



Base Headquarters at Baer Field, installation of the First Troop Carrier Command, Fort Wayne, Indiana

right into combat zones to spread destruction among the foe, but these same planes save lives. They save precious American lives by supplying troops with food and equipment via air—sometimes the only way possible—and by evacuating battle casualties, assuring the wounded of quick journeys back to base hospitals with expert care en route.

Training grounds for the pilots and flight nurses who fly the skyroads into danger in their unarmed “workhorses of the air” are the ten bases of the First Troop Carrier Command, which has its headquarters at Stout Field, in Indianapolis.

Troop carriers dropped the first American paratroopers in North Africa, spearheaded the invasion of Sicily, landed infantrymen to cinch the battle of New Guinea, carried troops far behind the Japanese lines in Burma, and led the way into Normandy on the fateful morning of June sixth. Those were the trips into battle. But now let us look at the road back. For these journeys the Troop Carrier Command’s warplanes become mercy planes.

The story of the evacuation of casualties by air can be told best by glancing over the accomplishments of hospital planes since our troops plunged into France. Air evacuation from the Cherbourg Peninsula to Britain is a function of the Troop Carrier Command of the Ninth Air Force, and has been a priority assignment of every Troop Carrier plane returning from Normandy. Operations have been limited only by the availability of landing strips on the invasion front.

While the first landing strips were intended exclusively for fighter planes and fighter bombers supporting the ground forces, it was possible to begin air evacuation operations earlier than planned, by making these strips available to transport planes carrying in essential supplies at times when combat aircraft were in the air.

Actual movement of the patients at the beach-head and at air bases in England was closely supervised by flight surgeons. Notified that a certain number of transports would arrive on the strip at a designated hour, and knowing the capacity of each



Wounded men are speeded to a base hospital from a South Pacific fighting front via a Troop Carrier Command hospital plane.



Soldier wounded in South Pacific fighting is placed aboard a Troop Carrier Command air evacuation plane.

plane, flight surgeons on the beach would select the casualties to be evacuated and have them moved from control hospitals to the specified airfield.

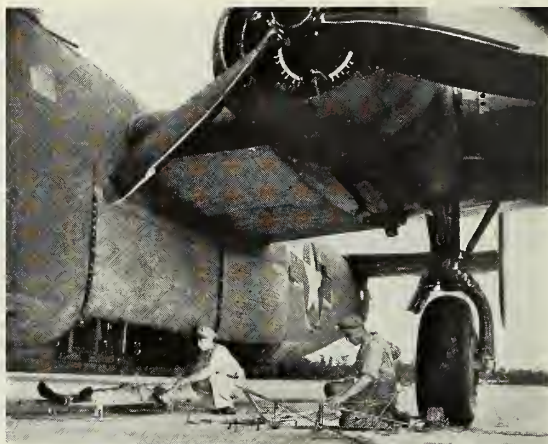
FLIGHT SURGEONS IN COMMAND

In flight, emergency medical care was provided by flight nurses and surgical technicians working in teams aboard each plane. As soon as the casualties arrived in England, they were removed under direction of flight surgeons to nearby hospitals. In the early days of the invasion the only persons, other than wounded, permitted to ride on transport aircraft returning to England were aircrew members who had lost their planes and couriers carrying vital messages.

Several hundred flight surgeons, flight nurses, and enlisted technicians are assigned to the duty of bringing the wounded out of France under the protecting umbrella of fighter planes. In the twenty-one days from June tenth to July first, the Troop Carrier Command transported 7,432 casualties, including Allies and a few prisoners of war, from Normandy to Britain.

The world over, our planes now carry about 1,000 patients a day. Major General David N. W. Grant, air surgeon of the Army Air Forces, has revealed that in the period between the Japanese attack on Pearl Harbor and D-Day in France sick and wounded soldiers of the United States and Allied forces were flown 250,000 times by American military aircraft. Most casualties made more than one flight during their evacuation.

So that air evacuation may go forward smoothly and speedily, flight surgeons, nurses, and enlisted personnel take a special training course at Bowman



At an AAF station a medical officer checks his "patient" on the litter, while the assistant engineer of the plane prepares a litter support frame for installation in the bomb rack.

Field, Louisville, Kentucky, home of the AAF School of Air Evacuation. Often referred to as one of medicine's greatest developments in this war, air evacuation is a realization of a dream Army medical officers had for many years.

The story of the Troop Carrier Command began just a little more than two years ago—on April 30, 1942, when its first commanding officer walked out of Army Air Forces Headquarters in Washington with his orders and a promise of fifty transport planes and a handful of men, most of them airline pilots, to guide them. Training was begun immediately, and in an incredibly short time a vast organization was built. The Command now numbers its planes and pilots in the thousands.



*Official Photographs—Army Air Forces
Presentation of Air Medal to three nurses who have returned from overseas assignment—at Bowman Field, Kentucky*

ARMY AIR FORCE REPRESENTATIVES ON INDIANA PROGRAM

Vice Admiral Ross T. McIntire, chief of the Bureau of Medicine and Surgery, the twenty-third to hold that office was born at Salem, Oregon, on August 11, 1889.



Admiral McIntire

He was appointed to the office of Surgeon General of the Navy on December 1, 1938, by President Franklin D. Roosevelt, being forty-nine years of age at the time of his appointment.

Admiral McIntire received his degree of Doctor of Medicine in 1912 from the Medical School of Willamette University, now the Medical School of the University of Oregon. At the beginning of the World War he was commissioned an assistant surgeon in the Medical Corps of the United States Navy with the rank

of Lieutenant, Junior Grade. His first commission was dated April 4, 1917, two days before the United States declared war on Germany. He completed a postgraduate course at the Naval Medical School, Washington, D.C., in Naval Medicine. From July, 1917, until January, 1920, he served at sea on board the *U.S.S. New Orleans*, and he holds the Victory Medal with Escort Clasp. His subsequent service included a short period at the Naval Hospital, Canacao, Philippine Islands, and a year in the Naval Medical School, Washington, D.C., from which he was assigned as head of the Eye, Ear, Nose and Throat Department of the Naval Hospital, San Diego, California. He has also served twice at sea on the hospital ship, the *U.S.S. Relief*, both times as head of the Department of Eye, Ear, Nose and Throat. In 1931 he returned from the *Relief* to the Naval Hospital, Washington, D.C., and assumed additional duty as instructor in ophthalmology and otolaryngology at the Naval Medical School. Two years later he was assigned to temporary additional duty as physician at the White House, and on February 13, 1935, he was appointed the regular physician to the White House with additional duty at the Naval Hospital. He accompanies the President on his numerous inspection trips with the fleet at sea or to overseas bases, and also on official journeys ashore.

Doctor McIntire is a specialist of distinction in ophthalmology and otolaryngology. He is a graduate of special postgraduate courses in these subjects and in bronchoscopy. He is a member of the American Medical Association, the Association of Military Surgeons, and a Fellow of the American College of Surgeons.

As Surgeon General of the Navy, he has had the important duties in connection with the expansion of the Medical Department of the Navy in the present national emergency. This includes the great and rapid increase in the numbers of all naval medical personnel, medical officers, dental officers, pharmacists, nurses, and enlisted men. The building of many new naval hospitals and the expansion of facilities of those already in existence, with the purchase and installation of equipment, were among these important tasks. Arrangements for the establishment of Medical Department facilities at the new bases from Newfoundland to South America had to be made. Coincident with the performance of this work, it was necessary to maintain research in various branches of naval medicine to keep abreast of the rapidly-changing developments brought out by the war.

As chief of the Bureau of Medicine and Surgery, he is a Vice Admiral, Medical Corps, United States Navy, with the title of Surgeon General, United States Navy.

Major General David N. W. Grant, the Air Surgeon, is a member of the Air Staff of the Commanding General, Army Air Forces, and as such is charged with



General Grant

the responsibility of planning and directing: (1) the operation and supply of all Army Air Forces medical services and facilities; (2) the aero medical research program; (3) air evacuation of the sick, injured, and wounded; (4) the convalescent training and rehabilitation program, and (5) the preparation of a history of military aviation medicine. Born in Richmond, Virginia, on May 14, 1891, General Grant received his degree as Doctor of Medicine at the University of Virginia in 1915. He entered active duty as a

Medical Reserve Corps officer in 1916, and the following year was appointed First Lieutenant in the Regular Army. During World War I he served in Panama, and for a short time in stations in the United States. He was promoted to captain and major in 1918, and in 1919 took command of the Sanitary Train which joined the Army of Occupation in Germany. After tours of duty at various medical stations following the war, he attended the School of Aviation Medicine in 1931, and was stationed at Randolph Field, Texas, for the subsequent five years. Following attendance at the Air Forces Tactical School, Maxwell Field, Alabama, and the Chemical Warfare School, Edgewood Arsenal, Maryland, General Grant was appointed Chief of the Medical Division, Office, Chief of the Air Corps in 1939, and in 1941 was promoted to colonel. Upon reorganization of the Army of the United States, he was appointed Air Surgeon, Headquarters, Army Air Forces. He was promoted to Brigadier General in 1942 and to Major General in 1943. In 1940, General Grant went to England as Medical Military Air Observer, and since that time has made inspection trips in all theatres of operations in World War II.

Brigadier General Fred Wharton Rankin, United States Army, was born in Mooresville, North Carolina, received the degree of Bachelor of Arts at Davidson



General Rankin

College in 1905, the degree of Doctor of Medicine at the University of Maryland in 1909, and the degree of Master of Arts from St. John's College in 1915.

From 1922 to 1923 he was Professor of Surgery at the University of Louisville. From there he went to the University of Minnesota as Associate Professor of Surgery. From 1926 to 1933 he was Chief of the Surgical Section and Associate Professor of Surgery at the Mayo Clinic. During World War I he served for seventeen months with the Medical Corps.

He is the author of *Surgery of the Colon* and co-author of *The Colon, Rectus, and Anus; Cancer of the Colon and the Rectus*; and contributor in Lewis' *Surgery* and Christopher's *Surgery* of the articles *Malformations*

of the Colon; Carcinoma of the Rectum; and Carcinoma of the Colon, and author of numerous papers on clinical surgery and surgical pathology in the literature.

In 1941 he was elected President of the American Medical Association, and took office in June, 1942. He is president of the Interstate Post-Graduate Assembly, vice-chairman of the American Board of Surgery, and council member of the Southern Surgical Association.

He received an honorary degree of Doctor of Science

from the following: Davidson College, University of Maryland, and University of Kentucky. He received an honorary degree of Doctor of Laws from Temple University in February, 1943, and an honorary degree from Northwestern University in June, 1943.

On March 1, 1942, Brigadier General Rankin was called to active duty with the Surgeon General's Office, United States Army, where he is chief consultant in surgery to the United States Army.

Thanks Again!



Arrangements for the Ninety-fifth Annual Session of the Indiana State Medical Association and this issue of *THE JOURNAL*, in cooperation with the Air Force Medical Services, could not have been completed without the advice and aid of many persons. To all those who helped make these arrangements, the editors and staff of *THE JOURNAL* and the officers of the Indiana State Medical Association express their appreciation and thanks.

It is impossible to name each individual who helped in innumerable ways by assembling articles, obtaining clearance with proper military authorities, obtaining photographs, preparing biographical sketches, lending cuts, and a thousand and one other ways.

Among those to whom we are particularly indebted and wish to thank are:

Lieutenant Colonel C. G. Weigand, Medical Corps, Chief of the Publications Branch, Research Division, Office of The Air Surgeon, Headquarters Army Air Forces, who was responsible for assembling the original articles for this issue, together with Colonel William P. Holbrook, Medical Corps, Chief of the Medical Services Division, Office of The Air Surgeon, and others of their staffs.



Lieutenant Colonel
C. G. Weigand

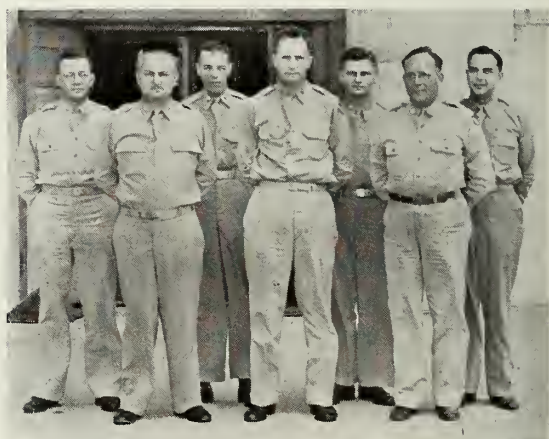
Colonel Ralph T. Stevenson, The Surgeon of the First Troop Carrier Command, and Lieutenant Colonel Dudley Pfaff, Assistant Surgeon of the First Troop Carrier Command, and Major V. P. Wilber, Command Public Relations Officer—all of Stout Field—for their assistance in supplying us with data concerning Indiana's contribution to the AAF, together with photographs.

Major M. P. Kelsey, editor of *The Air Surgeon's Bulletin*, Aero Medical Laboratory, Wright Field, Dayton, Ohio, for his assistance in lending art work and plates, used in *The Air Surgeon's Bulletin*, for reproduction in this issue of *THE JOURNAL*.

Colonel Howard A. Rusk, Chief of the Convalescent Training Division, and Major Donald A. Covalt, Executive Officer of the Convalescent Training Division, Office The Air Surgeon, for bringing the Army Convalescent Program Exhibit to our state meeting.

Captain Joseph E. Hamilton, of the Army Service Forces, Army Medical Center, for arranging for the Army Burn Exhibit.

And last but not least, Lieutenant Colonel Michael J. O'Connor, M.C., Executive Officer, Professional Division, Office of the Air Surgeon, Headquarters, Army Air Forces, and Lieutenant G. G. Gross, USNR, Division of Publications, Information Section, Bureau of Medicine and Surgery, Navy Department, for their part in the arrangement of the program.



Command Surgeon and Staff: Left to right—Major George A. Long, D.C.; Major Francis J. Nied, MAC; Major Edward M. Holmes, M.C.; Colonel R. T. Stevenson, M.C.; Major George J. Kridera, M.C.; Lieutenant Colonel Dudley A. Pfaff, and Chief Warrant Officer Frank C. Hale, USA, at Stout Field, Indianapolis, Indiana



Hoosier Heroes Of The Air

GENE DAWSON

Aviation Editor, The Indianapolis News

INDIANAPOLIS

The axiom that in any venture which is successful you will find a Hoosier running the show or playing an important part certainly is true of aviation, be it military or peacetime flying, for among the boys who are flying this nation's deadliest fighters and bombers, and making the best records at it in this deadliest of all wars, there is an ample sprinkling of young men imbued with the spirit that seems to have been reserved to the Hoosier soil.

There are so many heroes of the air from Indiana in this war that to list them all would be an impossible task. Perhaps the wisest course, then, would be to limit personal mention to the two Hoosier leaders.

One, and perhaps the best known, is Major Walker M. Mahurin, a native of Fort Wayne, who was leading the pack of the nation's fighter pilots when he was shot down. He came back with a record of more than twenty enemy planes to his credit, and as one of the great air heroes of the war up to that time.

Leading the entire Navy in the destruction of enemy planes is another Indiana man, Lieutenant Alexander Vraciu, Jr., of East Chicago, with nineteen Japanese craft notched on the barrels of his Navy "Hellcat" guns.



Major Walker M. Mahurin

At the present time Major General George Edward Stratemeyer of Peru, Indiana, is the highest-ranking Hoosier in the Air Forces. General Stratemeyer is serving in the Southeastern Theatre with Lord Mountbatten, who is in charge of all Allied Forces in that area.

They are carrying on the traditions of Indiana's limited number of aces in World War I, when the American Air

Force was just a collection of instable, motor-equipped kites which, nevertheless, outdid the German Flying Circus.

They are very much like the Thomas G. Cassidys, the Paul Baers, the Norman Schoens, the Weir Cooks, and the others from Indiana who made it hot for the "Huns" in the 'teens of this century, when the world was on fire before. Cassidy came from Worthington, Baer from Fort Wayne, and Schoen and Cook from Indianapolis. Some of them were members of the famous Hat-in-the-Ring Squadron led by the ace of aces of World War I, Captain Eddie Rickenbacker, who has deep-rooted Indiana connections.

It was out of that group of young men who risked their necks in crates that Indiana got her nucleus for the development of aviation as we know it today. For example, there is Baer Field at Fort Wayne, now an important Army air base. There is the old Schoen Field near Fort Benjamin Harrison, Indianapolis, which gave way to Stout Field when the First Troop Carrier Command needed more room. There also is Weir Cook Municipal Airport in Indianapolis, named for the only ace of World War I who lost his life flying in the service of his country during that war.



Lieutenant Alexander Vraciu, Jr.

These men carried on when the going was tough, to make this nation aviation conscious. The value of their work can only be measured by the successes scored every day by their disciples in World War II.

Since that time Indiana has adopted another flyer, perhaps the best known of them all in peacetime activity, Roscoe Turner, who now operates a \$500,000 aeronautical corporation on Weir Cook Municipal Airport. And, Indiana has developed more than 100 accredited airports from which hundreds of aircraft of all types are flying every day. There were more than 170,000 take-offs and landings at Weir Cook Municipal Airport in 1943.

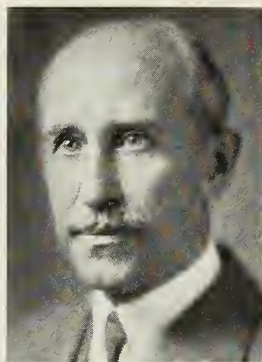
Two Hoosiers Start It All

Any surprise at Indiana's pre-eminence in the field of aviation disappears with examination of the record. Aviation, as we know it, was a'll but born in Indiana. Literally, its inventors, the Wright Brothers, were born on Hoosier soil, near Millville.

Orville and Wilbur Wright were both born in Indiana. Wilbur Wright was educated in the public schools at Richmond, completing his education at Dayton when his father, Milton Wright, an itinerant preacher, moved there. He and his brother opened a small printing shop and eventually a bicycle repair shop, out of which grew the manufacture of the first airplane that flew at Kitty-Hawk in North Carolina.

However, Indiana's contribution to aviation antedates even the Wright Brothers. Our neighboring city of Lafayette played an important role in the early history of air mail delivery. It was on August 17, 1859, that the first air mail delivery took place, with Lafayette as its starting point. Professor John Wise, a balloonist from Lancaster, Pennsylvania, believed that he had found "secondary trade winds" originating in the Mississippi River Valley flowing eastward, and conceived the idea of delivering the mail by balloon flight. The Postoffice Department sanctioned the experimental flight, and at 6:00 p.m. on August 17, 1859, the first letters and parcels were delivered by air to the neighboring city of Crawfordsville, followed by subsequent deliveries to Lancaster, Pennsylvania, and a final delivery of 123 letters to New York City. It was the first air mail delivery in the world, and it took root on our own Hoosier soil. Many years later, in 1919, when the Postoffice Department first established a scheduled air mail service, a man who now is a leading figure among Indiana aviators was one of four pilots flying the route from New York to Washington. He is Bob Shank, the proprietor of the Hoosier Airport in Indianapolis.

Also antedating the Wright Brothers was the organization of one of the first aeronautical corporations ever formed, right in the Hoosier capital. It was on April 14, 1892, that the Brightwood Aerial Navigation Company was formed in the northeastern part of Indianapolis. Its president



Orville Wright

was Boyd M. Ralston, who died only recently, and the inventor of the air machine which never flew was a young man named Walter Mercer, who proposed to raise and lower his steam-driven airplane by rotating fans atop the motor. Sounds like the predecessor of the much-discussed Helicopter, doesn't it? It never flew, but neither did a lot of the first models of air-

planes. Neither do a lot of cures work until they've had the bugs taken out. So, these Hoosier pioneers kept at it, and finally it was the two youngsters from Millville who startled the world with the statement that they had become the first to conquer the air with a motor-driven conveyance.

Indiana on the Air Map

Now, an Indiana-born man still is designing the newest things in aircraft for Uncle Sam's army. He is Brigadier-General Franklin O. Carroll, a native of Washington, Indiana, who is chief of all Army experimental work in aircraft design at the Materiel Command Headquarters at Wright Field, Dayton, Ohio.

Working with him there is another Indiana-born general, Brigadier-General Orval R. Cook, who was born and educated at West Union, Indiana. General Cook is chief of the production division of the Army Air Forces Materiel Command at Wright Field.

General Carroll works out the designs, and it is General Cook's job to see that they are produced. That is where almost 100,000 Indiana workmen, skilled and unskilled, enter the aviation picture. They are employed in working on military aviation contracts in Indiana which, the Materiel Command public relations department says, will approximate \$3,000,000,000.

These contracts are distributed, says the Materiel Command, among approximately 700 aviation contractors in Indiana, making everything from the deadly B-17 Flying Fortress motor to the smallest part that adds precision to military flying. These contractors are scattered about the state from South Bend to Evansville.

At South Bend, Studebaker makes the B-17 motor, and the Bendix Corporation makes the gun turrets. At Fort Wayne, the General Electric Company makes myriad electrical parts that go into almost every type of airplane. At New Castle, the Firestone Tire & Rubber Company makes fuel cells that hold even after they have been punctured. At Anderson, the Delco-Remy Corporation makes hundreds of electrical items for airplanes. The Warner Gear Company at Muncie does its part

with hundreds of items. At Indianapolis, the Allison Division of the General Motors Corporation makes the famous and unexcelled Allison liquid-cooled motor, while another G-M plant, the Chevrolet Commercial Body Division, turns out parts for the Pratt & Whitney engine, the type that powers the deadly P-47 Thunderbolt made by the Republic Aviation Corporation at Evansville. It is at Evansville, too, that the Servel Corporation makes the wings for the P-47, which now represents 60 per cent of all of this nation's fighter planes.

And, did you know that the biggest of all para-

chute factories in America is at Washington, Indiana? It is the Reliance Manufacturing Company, which makes both personnel and aerial delivery parachutes.

These are only a few of the largest of Indiana's war plants sending hundreds of fighters and bombers every day into the heart of enemy territory.

When victory is won, the mustached little guy who runs the show in Germany may be convinced that when he set about to create a super race, he should have come to Indiana for the basic stock.

Announcements

INSTRUCTIONAL COURSES

Make your reservation early for the Instructional Courses as the number of men who can be accommodated for each course is limited.

NOTICE!

Any class, alumni or fraternity group desiring to make arrangements for a meeting during the state convention should get in touch with John W. Hendricks, M.D., chairman of the Fraternity and Class Reunion Committee for the annual session, 445 North Pennsylvania Street, No. 707, Indianapolis, Indiana.

LOYOLA ALUMNI LUNCHEON

Loyola graduates will have a luncheon together Tuesday noon, October 3, the first day of the annual state meeting at the Athenaeum. Special arrangements will be made at the registration desk at the Murat Temple, session headquarters, for all Loyola alumni to register. You are asked to report to the registration desk Tuesday morning.

Dr. Frank B. Fisk, of Indianapolis, is serving as

local chairman; and Dr. Homer G. Gable, of Monticello, is state counselor. G. G. Grant, S. J., alumni secretary of Loyola University, will be the principal guest and speaker.

ARMY BURN EXHIBIT

One of the most interesting, complete, and instructive displays shown at the American Medical Association meeting in Chicago last June was the Army Burn Exhibit. This exhibit will be one of the features of the ninety-fifth annual session of the Indiana State Medical Association, in Indianapolis, and will amplify the talk which will be made by General Fred B. Rankin of the Surgeon General's Office, at the War Participation luncheon on Wednesday, October 4, the second day of the session.

Captain Joseph E. Hamilton, M.C., Army Service Forces, Washington, D.C., will be in charge of the exhibit which will be placed near the entrance of the convention hall at the Murat Temple.

Invitation to State Meeting

As chairman of the Committee on Arrangements for the Ninety-fifth Annual Session of the Indiana State Medical Association, to be held in Indianapolis, October 3, 4, and 5, I invite and urge all members to be present.

In spite of the war situation we are anticipating an excellent meeting. In the interest of the profession, a fine array of talks, conference hours, and exhibits has been arranged. Entertainment this year will be the best ever, since we are planning a full evening of fine broadcast entertainment after the smoker on Tuesday. The ladies will be invited to the entertainment.

This Committee wishes to extend a hearty welcome to everyone, and sincerely believe you will be well repaid.

COMMITTEE ON CONVENTION ARRANGEMENTS

Bert E. Ellis, M.D., *Chairman*,
Gordon Batman, M.D.,
Walter Moenning, M.D.



Official Program

95TH ANNUAL SESSION

INDIANA STATE MEDICAL
ASSOCIATION

IN CONJUNCTION WITH

ARMY AIR FORCE MEDICAL
SERVICES

MURAT TEMPLE

508 N. New Jersey Street

INDIANAPOLIS, INDIANA

October 3, 4 and 5, 1944

Monday, October 2, 1944

Meeting of state health officers.

6:30 p.m. Executive Committee dinner and meeting,
Columbia Club.

12:30 p.m. Council meeting, Kueipe Room, Murat Temple.

2:00 to 5:00 p.m. Instructional courses, Murat Temple.

4:00 p.m. Meeting of House of Delegates, Murat Theater.

Tuesday, October 3, 1944

Morning

8:00 a.m. Registration starts, lounge room, Murat Temple.

8:00 a.m. Opening of scientific and commercial exhibits, lounge room, Murat Temple.

11:00 to 12:00 m. Instructional courses, Murat Temple.

Afternoon

12:15 p.m. Luncheon meeting of members of the state and county Anti-Tuberculosis Committees, Banquet Hall, basement, Murat Temple.

Speaker: PAUL H. HOLINGER, M.D., Assistant Professor of Laryngology, University of Illinois College of Medicine, Chicago, Illinois.

Subject: *Bronchoscopic Diagnosis of Bronchial Tumors.* (Technicolor movie visualization of lesions of bronchial tract.)

X-ray conference sponsored by Indiana Chapter, American College of Chest Physicians.

12:15 p.m. Loyola Alumni luncheon, Athenaeum.

Evening

6:30 p.m. Annual dinner meeting for women physicians, Hunters Lodge, Marott Hotel.

Speaker: LILLIAN B. MUELLER, M.D., Indianapolis.

Subject: *The Teaching of Anesthesia.*

Evening

7:00 p.m. Buffet supper, smoker and stag party, Recreation Room, Murat Temple.

Wednesday, October 4, 1944

Morning

7:30 a.m. Breakfast meeting of members of the state and County Conservation of Vision Committees, Parlor A, Indianapolis Athletic Club.

Speaker: C. W. RUTHERFORD, M.D., Indianapolis.

8:00 a.m. Registration continues, lounge room, Murat Temple.

8:00 a.m. Scientific and commercial exhibits, lounge room, Murat Temple.

GENERAL MEETING

Wednesday, October 4, 1944

Murat Theater

9:00 a.m. Call to order by J. T. Oliphant, M.D., Farmersburg, president, Indiana State Medical Association.

9:05 a.m. Greetings and introduction of Harry L. Foreman, M.D., Indianapolis, president of the Indianapolis Medical Society, by Bert Ellis, M.D., chairman of the Committee on Convention Arrangements.
Official welcome by Robert H. Tyndall, Mayor of Indianapolis.

9:15 a.m. President's Address, J. T. Oliphant, M.D., Farmersburg.

SCIENTIFIC PROGRAM

9:30 a.m. MAJOR GENERAL DAVID N. W. GRANT, Air Surgeon, United States Army, Washington, D.C.

Subject: *Medical Aspects of Pressurized Aircraft.*

10:00 a.m. NEWELL CLARK GILBERT, M.D., Professor of Medicine, Northwestern University Medical School, Chicago, Illinois.

Subject: *Functional Disturbances vs. Organic Heart Disease.*

10:30 a.m. CHESTER SCOTT KEEFER, M.D., Wade Professor of Medicine, Boston University School of Medicine, Boston, Massachusetts.

Subject: *Indications and Methods of Use of Penicillin.*

11:00 a.m. VIRGIL S. COUNSELLER, M.D., Associate Professor of Surgery, University of Minnesota Graduate School, Minneapolis-Rochester, Minnesota.

Subject: *Indications for Radical vs. Conservative Treatment for Gynecological Conditions.*

11:30 a.m. COLONEL HOWARD A. RUSK, M.C., Chief, Convalescent Training Division, Office of the Air Surgeon, Washington, D.C.

Subject: *New Horizons in Management of Convalescents.*

Afternoon

12:15 p.m. Fraternity, class, special committees, and servicemen's luncheons and get-togethers.

12:15 p.m. War Participation Luncheon, Caravan Club Room, Murat Temple. Charles R. Bird, M.D., Chairman, Procurement and Assignment Service for Indiana, presiding.

Speakers:

BRIGADIER GENERAL FRED W. RANKIN, United States Army, Office of the Surgeon General, Washington, D.C.

Subject: *Advances in Army Medicine.*

VICE ADMIRAL ROSS T. McINTIRE, M.C., Surgeon General, United States Navy, Washington, D.C.

Subject: *Medical Aspects of Naval Warfare.*

SECTION MEETINGS

Wednesday, October 4, 1944

MEDICAL SECTION

Chairman, Eugene F. Boggs, M.D., Indianapolis
Vice-chairman, Wemple Dodds, M.D., Crawfordsville
Secretary, Marion R. Shafer, M.D., Indianapolis

(Murat Theater)

2:00 p.m. NEWELL CLARK GILBERT, M.D., Chicago.

Subject: *The Treatment of Rheumatic Fever.*

2:30 p.m. General Discussion.



Paul H. Holinger,
M.D.



Newell Clark Gilbert,
M.D.



Chester Scott Keefer,
M.D.



F. S. Counsellor,
M.D.



Major John Bellows



Major Randolph L.
Clark, Jr.

2:45 p.m. A. J. Sparks, M.D., Fort Wayne.

Subject: *Upper Urinary Tract Symptoms of General Interest.*

4:00 p.m. VIRGIL S. COUNSELLER, M.D., Rochester, Minnesota.

Subject: *Vesicovaginal Fistula.*

3:15 p.m. Discussion: WALTER P. MORTON, M.D., Indianapolis.

4:30 p.m. Election of Section officers.

3:30 p.m. CHESTER SCOTT KEEFER, M.D., Boston.
Subject: *The Treatment of Blood Stream Infections and Meningitis with Penicillin.*

4:00 p.m. Election of Section officers.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman, C. P. Clark, M.D., Indianapolis
Vice-chairman, H. C. Wurster, M.D., Mishawaka
Secretary, Kenneth L. Craft, M.D., Indianapolis

(Murat Egyptian Room Foyer No. 1)

2:00 p.m. Symposium: "The Use of Penicillin in Ophthalmology and Otolaryngology."

1. MAJOR DILLON D. GEIGER, M.C., Regional Station Hospital, Keesler Field, Mississippi.

Subject: *Penicillin in Otolaryngology.*

2. MAJOR JOHN G. BELLOWES, M.C., Wakeman General Hospital, Camp Atterbury, Indiana.

Subject: *Penicillin in Ophthalmology.*

3. Discussion: Lieutenant Colonel Gilbert C. Struble, M.C., Billings General Hospital, Fort Benjamin Harrison, Indiana.

4. Discussion: Gerald F. Kempf, M.D., Indianapolis City Hospital, Indianapolis.

4:00 p.m. Election of Section officers.

SURGICAL SECTION

Chairman, William H. Howard, M.D., Hammond
Vice-chairman, George Collett, M.D., Crawfordsville
Secretary, J. Robert Doty, M.D., Gary

(Murat Candidates Room)

2:30 p.m. MAJOR RANDOLPH L. CLARK, M.C., Consultant in Surgery to Air Surgeon, Aero Medical Laboratory, Wright Field, Dayton, Ohio.

Subject: *The Evolution of the Treatment of Pilonidal Cysts in Sinuses.*

3:00 p.m. E. B. MUMFORD, M.D., Indianapolis.

Subject: *Bone Grafts—Review of 103 Cases.*

3:30 p.m. LEO K. COOPER, M.D., Gary.

Subject: *Surgery of Trauma and Its Importance as an Emergency.*



Colonel Rust

Colonel Howard A. Rusk, M.C., Chief of the Convalescent Training Division, and Major Donald A. Covalt, Executive Officer of the Convalescent Training Division, Office of The Air Surgeon, are responsible for the Army Convalescent Program Exhibit being shown at this session.



Major Covalt



Ralph M. Waters,
M.D.



"Mickey" MacDougall

SECTION ON ANESTHESIA

Chairman, Russell W. Kretsch, M.D., Hammond
Vice-chairman, Harry Knott, M.D., Plymouth
Secretary, John M. Whitehead, M.D., Indianapolis

(Murat Egyptian Room Foyer No. 2)

2:00 p.m. RALPH M. WATERS, M.D., Professor of Anesthesia, University of Wisconsin Medical School, Madison, Wisconsin.

Subject: *Artificial Respiration.*

2:30 p.m. Discussion: George Rosenheimer, M.D., South Bend, and Floyd T. Romberger, M.D., Lafayette.

2:45 p.m. MAJOR DONALD S. THATCHER, M.C., Billings Hospital, Fort Benjamin Harrison, Indiana.

Subject: *The Correction of Protein Deficiency by Amino Acid Therapy in the Management of Surgical Patients.*

3:15 p.m. Discussion: Philip L. Kurtz, M.D., Indianapolis.

3:30 p.m. CHARLES N. COMBS, M.D., Terre Haute.
Subject: *The First Nitrous-Oxide Anesthesia Administered by Dr. Horace Wells, December 11, 1844.—A Memorial.*

4:00 p.m. Election of Section officers.

Annual Banquet

Wednesday, October 4, 1944

6:30 p.m. Reception for guests, foyer, Main Dining Room, Murat Temple.

7:30 p.m. Annual dinner, Banquet Hall, Murat Temple. Presiding officer, J. T. Oliphant, M.D., President, Indiana State Medical Association.

Presentation of Certificate of Merit to Carl H. McCaskey, M.D., president 1943, by J. T. Oliphant, M.D.

Speaker: To be announced.

Entertainment: Michael "Mickey" MacDougall, New York City.

Subject: *Card Sharks vs. Soldiers and Sailors.*

Thursday, October 5, 1944

7:15 a.m. House of Delegates breakfast meeting, Riley Room, mezzanine floor, Claypool Hotel. Annual election of officers and selection of convention city for 1945.

Meeting of Council immediately following adjournment of House of Delegates.

Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

INDIANAPOLIS

October 3, 4, and 5, 1944

COMMITTEES FOR INDIANAPOLIS CONVENTION

PUBLICITY COMMITTEE: Dr. Robert Jewett, chairman; Dr. Ray Newcomb, Dr. Herman Morgan.

RECEPTION COMMITTEE: Dr. Chester Stayton, chairman; Dr. Chester Stayton, Jr., Dr. E. T. Gaddy, Dr. Leonard Ensminger, Dr. Homer Hamer, Dr. H. H. Wheeler, Dr. Walter Kelly, Dr. Myron Harding, Dr. Richard Harding.

MILITARY RECEPTION COMMITTEE: Colonel Frederick Potter, chairman; Lieutenant Colonel Dudley Pfaff, Lieutenant Commander L. D. Bibler.

FINANCE COMMITTEE: Dr. H. H. Wheeler, chairman; Dr. Lyman Pearson, Dr. Norman S. Loomis.

INSTRUCTIONAL COURSES: Dr. Marlow Manion, chairman; Dr. Gordon Batman, Dr. Harold Trusler.

WOMEN PHYSICIANS COMMITTEE: Dr. Jane Ketcham, chairman; Dr. Olga Booher, Dr. Martha Souter, Dr. Lillian Mueller.

BANQUET COMMITTEE: Dr. Walter Moenning, chairman; Dr. Ross Griffith, Dr. Simon Reisler, Dr. Jerome Littell.

LANTERN COMMITTEE: Dr. Robert Glass, chairman; Dr. J. N. Collins, Dr. Clyde Culbertson.

SMOKER AND STAG PARTY COMMITTEE: Dr. C. E. Cox, chairman; Dr. John Brayton, Dr. Arthur Funkhouser.

FRATERNITY AND CLASS REUNION COMMITTEE: Dr. John W. Hendricks, chairman; Dr. E. O. Alvis, Dr. Ernest Rupel.

ENTERTAINMENT COMMITTEE: Dr. Kenneth Kohlstaedt, chairman; Dr. David Jones, Dr. Frank Teague.

MURAT TEMPLE



Headquarters for the ninety-fifth annual session of the Indiana State Medical Association, to be held in Indianapolis on October 3, 4, and 5, will be the Murat Temple. Registration, scientific exhibits, commercial exhibits, scientific meetings, the business sessions of the House of Delegates and Council, annual dinner meeting, and practically all activities of the state meeting are to be held in the Temple and the spacious and convenient Murat Theater of the Temple.

Women, Attention Please!

We hope that the wife of every physician in Indiana will accompany her husband to the State Convention on October 3, 4, and 5. The women of Marion County are busy making arrangements for your entertainment. Plan to bring your husband, and come to Indianapolis to relax those few days.

Due to the present war emergency, the women's activities at the convention will necessarily be curtailed to some extent, but we do want you to come. You will have a good time even though the get-together will be on a more informal basis than in previous years.

The Woman's Auxiliary business session will be held as usual, preceded by a breakfast.

The highlight of our entertainment this year will be a tea at the home of Governor and Mrs. Henry F. Schricker, on October third, at 4:00 p.m., honoring our National President, Mrs. David W. Thomas. Mrs. Schricker is a gracious hostess and a very charming person. We are sure you will all enjoy meeting Mrs. Schricker and Mrs. Thomas.

Please join us in Indianapolis.

Mrs. Henry S. Leonard, *Chairman,*
Woman's Entertainment Committee.

Women's Entertainment

CONVENTION COMMITTEE—WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION

Convention Arrangements: Mrs. Henry S. Leonard, chairman; Mrs. John W. Carmack, Mrs. Harry L. Foreman, Mrs. William E. Gabe, Mrs. Harry R. Kerr, Mrs. Cleon A. Nafe, and Mrs. J. E. Holman—all of Indianapolis.

Registration and Credentials: Mrs. John Carmack, Indianapolis.

Convention Rules of Order: Mrs. I. H. Scott, Sullivan.

Resolutions: Mrs. Harold Trusler, Indianapolis.

Nominations: Mrs. A. W. Ratcliffe, Evansville.

Revisions: Mrs. Charles F. Voyles, Indianapolis.

Timekeepers: Mrs. Samuel M. Baxter, New Albany, and Mrs. R. G. Burman, Jeffersonville.

Press and Publicity: Mrs. Arthur B. Richter, Indianapolis.

Tuesday, October 3, 1944

- 8:00 a.m. *Registration*, Lounge Room, Murat Temple.
 1:00 p.m. *Board Meeting*, Louis XIV Room, mezzanine floor, Claypool Hotel.
 4:00 p.m. *Tea*, honoring Mrs. David W. Thomas, Lock Haven, Pennsylvania, President of the Woman's Auxiliary to the American Medical Association, at the home of Governor and Mrs. Henry F. Schrieker, 101 E. 27th Street.
 8:30 p.m. *Entertainment* in conjunction with the Indiana State Medical Association, Murat Theater.

Wednesday, October 4, 1944

- 8:15 a.m. *Annual Auxiliary breakfast and business meeting*, Terrace Tea Room, William H. Block and Company. (Use Market Street entrance. Doors open at 8:00 a.m. Price, \$1.25. Must have reservation.)
 9:00 a.m. to
 12:30 p.m. *Business Meeting*.

ORDER OF BUSINESS

Presiding—Mrs. James W. Baxter, Jr., New Albany, President of the Woman's Auxiliary to the Indiana State Medical Association.

Invocation—Rev. George S. Henninger, Indianapolis.

Pledge of Allegiance.

Welcome—Mrs. Karl M. Koons, Indianapolis.

Response—Mrs. F. B. Wishard, Pendleton.

In Memoriam—Mrs. Wayne Elsten, Lapel.

Presentation of the President-elect—Mrs. Frank M. Gastineau, Indianapolis.

Introduction of Mrs. Henry S. Leonard, Indianapolis, President of the Marion County Auxiliary and chairman of convention committee.

Address—Mrs. David W. Thomas, Lock Haven, Pennsylvania, president of the Woman's Auxiliary to the American Medical Association.

Convention Rules of Order—Mrs. I. H. Scott, vice-president, Sullivan.

Roll Call—Mrs. E. T. Stahl, secretary, Lafayette.

Minutes of preceding annual session—Mrs. E. T. Stahl, secretary, Lafayette.

Credentials and Registration—Mrs. John Carmack, Indianapolis.

President's message—Mrs. James W. Baxter, Jr., New Albany.

Report of American Medical Association convention—Mrs. Arnold H. Duemling, Fort Wayne, counselor.

REPORTS OF OFFICERS AND CHAIRMEN:

Treasurer—Mrs. A. W. Ratcliffe, Evansville.
Auditors—Mrs. Mell B. Welborn, Evansville.

Recording Secretary—Mrs. E. T. Stahl, Lafayette.

Corresponding Secretary—Mrs. John H. Habermel, New Albany.

Archives—Mrs. W. E. Tinney, Indianapolis.

Bulletin—Mrs. Ernest O. Nay, Terre Haute.

War Participation—Mrs. Maurice B. Van Cleave, Terre Haute.

Finance—Mrs. C. E. Munk, Kendallville.

Hygeia—Mrs. George R. Dillinger, French Lick (Thomasville, Georgia).

Legislation—Mrs. F. B. Wishard, Pendleton.

Organization—Mrs. Herbert A. Ray (northern), Fort Wayne; Mrs. Frank M. Gastineau (southern), Indianapolis.

Program—Mrs. E. N. Mendenhall, Fort Wayne.

Press and Publicity—Mrs. Arthur B. Richter, chairman, Indianapolis.

Historian—Mrs. U. G. Poland, Muncie.

Pioneer Memorial—Mrs. O. G. Pfaff, Indianapolis.

Report of special finance committee—Mrs. C. E. Munk, Kendallville.

Revisions—Mrs. Charles F. Voyles, Indianapolis.

Reports of county presidents.

Resolutions—Mrs. Harold Trusler, Indianapolis.

Report of Nominating Committee—Mrs. A. W. Ratcliffe, chairman, Evansville.

Election of officers.

Installation of officers—Mrs. Charles F. Voyles, Indianapolis.

Presentation of president's pin and gavel.

Inaugural address—Mrs. Frank M. Gastineau, Indianapolis.

New Business.

Adjournment.

7:30 p.m. *Annual Dinner* in conjunction with the Indiana State Medical Association, Banquet Hall, Murat Temple.

INSTRUCTIONAL COURSES—Tuesday, October 3, 1944

The instruction courses offered for the first time at last year’s meeting of the Indiana State Medical Association were so enthusiastically received by the membership that a similar program will be given at the meeting this year.

The sixteen courses listed below will be held on Tuesday, October third, the opening day of the meeting at the Murat Temple. The discussions will be in a practical vein. Each course will accommodate twenty members. It therefore will be wise for you to use promptly the attached application for reservation of tickets. Reservations will be made in the sequence of their arrival at our office—first come, first served. Registration cost will be one dollar (\$1.00) per course, or three dollars (\$3.00) for four courses.

11:00 A.M.	Indications for Use of Sulfonamide Drugs and Penicillin Course A	Analgesia in Obstetrics Course B	Recognition and Treatment of Common Skin Diseases Course C	Office Examination of the Heart Course D
2:00 P.M.	Diagnosis and Treatment of Anorectal Conditions Course E	Routine Neurological Examination Course F	The Present Status of the Treatment of Burns Course G	Office Treatment of Genito-Urinary Conditions Course H
3:00 P.M.	The Management of the Diabetic Course I	Office Examination of the Heart Course J	Hypertension Course K	The Management of Emergencies of the Upper Respiratory Tract Course L
4:00 P.M.	Treatment of Injuries of Wrist, Hand and Digits Course M	Recognition and Treatment of Common Skin Diseases Course N	Infant Feeding Problems Course O	Surgical Emergencies of the Abdomen Course P

ORDER BLANK

Kindly indicate your 1st, 2nd and 3rd choice of each hour, using the course letter, as Course A or Course N. Please enclose check for one dollar per course, or three dollars for four courses.

The reserved tickets will be awaiting you at the registration desk.

1st Choice	2nd Choice	3rd Choice	
11:00 A.M.			KINDLY PRINT YOUR NAME
2:00 P.M.			
3:00 P.M.			
4:00 P.M.			Name
			Address
			City

Send check and order blank to

INDIANA STATE MEDICAL ASSOCIATION,
1021 HUME-MANSUR BUILDING,
INDIANAPOLIS 4, INDIANA.

OFFICIAL CALL TO THE HOUSE OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at Indianapolis, October 3, 4 and 5, 1944.

The House of Delegates will be constituted as follows: Marion County, fourteen delegates; Lake County, five delegates; Allen County, three delegates; St. Joseph County, three delegates; Vanderburgh County, three delegates; Daviess-Martin, Dearborn-Ohio, Delaware-Blackford, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Madison, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County societies, each two delegates; the other sixty-seven county societies, each one delegate; thirteen councilors; the ex-presidents, namely: C. S. Bond, W. H. Stemm, W. R. Davidson, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, A. B. Graham, F. S. Crockett, J. H. Weinstein, E. E. Padgett, R. L. Sensenich, Herman M. Baker, E. M. VanBuskirk, Karl R. Ruddell, A. M. Mitchell, M. A. Austin, and Carl H. McCaskey. In addition to these, the president, secretary and treasurer, all without power to vote except in case of a tie, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly-executed credentials should be mailed to Thomas A. Hendricks, 1021 Hume-Mansur Building, Indianapolis 4, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 4:00 P.M., Tuesday, October 3, in the Murat Theater, Murat Temple, and again at 7:15 A.M., Thursday morning, October 5, in the Riley Room, mezzanine floor, of the Claypool Hotel (breakfast meeting).

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Report of executive secretary.
6. Report of the treasurer.
7. Report of the chairman of the council.
8. Reports of standing and special committees:
 - (1) Credentials.
 - (2) Executive Committee.
 - (3) Arrangements.
 - (4) Scientific Work.
 - (5) Public Policy and Legislation.
 - (6) Bureau of Publicity.
 - (7) Civic and Industrial Relations.
 - (8) Medical Education and Hospitals.
 - (9) JOURNAL Publication.
 - (10) Secretaries' Conference.
 - (11) Permanent Study of Committee on Health Insurance.

- (12) Necrology and History.
 - (13) Study of High School Athletics.
 - (14) Mental Health.
 - (15) Advisory Committee to the Bureau of Maternal and Child-Health of the Indiana State Board of Health.
 - (16) Liaison Committee of the Division of Services for Crippled Children.
 - (17) Auditing.
 - (18) Control of Cancer.
 - (19) Venereal Disease.
 - (20) Industrial Health.
 - (21) Indiana Inter-Professional Health Council.
 - (22) Anti-Tuberculosis.
 - (23) Conservation of Vision.
 - (24) Hard of Hearing.
 - (25) War Participation.
 - (26) Physical Therapy.
 - (27) Medical Relief.
 - (28) Rural Medical Care.
 - (29) OPA Medical Advisory Committee.
 - (30) Study of Lay Activity in Medical Practice.
 - (31) Scientific Exhibit.
9. Reading of communications.
 10. Reading of memorials and resolutions.
 11. Unfinished business.
 12. New business.
 13. Adjournment.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1944, and their successors must be elected at the session: Delegates to the American Medical Association to succeed H. G. Hamer, Indianapolis, and George Dillinger, French Lick; and alternates, J. E. Ferrell, Fortville, and A. S. Giordano, South Bend.

Delegates from the first, fourth, seventh, tenth and thirteenth districts are reminded that the terms of their councilors will expire December 31, 1944, and new councilors should be elected to succeed the following:

- | | |
|----------------------|---------------------------------------------|
| First District: | I. C. Barclay, Evansville. |
| Fourth District: | J. C. Elliott, Guilford. |
| Seventh District: | Walter L. Portteus,
Franklin (Pro tem.). |
| Tenth District: | William H. Howard,
Hammond. |
| Thirteenth District: | Alfred Ellison, South Bend. |

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

THOMAS A. HENDRICKS,
Executive Secretary.

Reports of Officers and Committees

EXECUTIVE SECRETARY

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

Broadcast in regard to our 1260 Indiana physicians who are in service:

Comes the Final Scene

Entire cast on stage.

Principals down stage, each crowding the footlights and edging his way to the place where he thinks the spotlight is going to shine brightest—Congressmen, Senators, Generals, Admirals banked row upon row.

Thunder of big guns is heard. The rumble of the barrage grows in intensity, pierced by the recurrent spatter of machine guns, the jar of high explosives, and the whirl of airplanes at full speed.

At back stage center from the highest tier appears a figure. Generals, Admirals, Congressmen, Senators, reporters, executive secretaries, public relations experts, publicity men, DeKruif, Kaiser, Falk, Wagner, and Murray fall back and gradually fade out of the picture.

The figure advances—slowly, a bit uncertainly. It is not a very military figure, although dressed in service khaki. In fact, his collar is open at the throat. His insignia is difficult to make out—is it a caduceus, or the oak leaf and acorn of the Naval Medical Corps, or the design of the Merchant Marine?—it's hard to tell which. However, you do make out a silver bar on his unbuttoned collar—one bar only—he's a lieutenant. As he advances slowly you see he has a scraggy growth of beard, for he's been working in a beachhead hospital evacuation tent for thirty-six hours without rest. The colonel and major and captains, and practically the whole medical staff, was wiped out by a Nazi dive bomber, and now for two days he has had to do everything, including the surgery, although it's easy to see that despite the beard and his tired eyes he's just a kid—in fact, hardly out of internship.

His cheeks are sunken, too, for he worked until he collapsed with malaria during those first months at Guadalcanal, and his face is still gray with sickness, for he was laid up with dengue following the three-week trek with Stilwell from Burma. And his arm is still bandaged, for he waded through that quarter of a mile—that's a long 440 yards—with the stretcher bearers in the first attack wave that went over the sides of the landing barges to the blood-sodden beach at Tarawa. And that Jap bullet wound hasn't yet completely healed in the jungle darkness. But he stuck it out and saw that

all had plasma and sulfa—and he checked to see that the dead were really dead. He's flown thousands of miles with the Troop Carrier Command. He's jumped with the paratroopers. He's drifted in an open boat and in a rubber life raft—the only trace left of his convoy—and saved men who otherwise would have died. And even at this hour, while we are here safe and comfortable, he may be living a death worse than death itself, for he was a prisoner on Bataan.

Yes, you're right—he's the spirit of those 50,000 American doctors in service.

Now he's puzzled, confused, and for the first time uncertain—finding himself there in the full flood of the spotlight—everyone looking at him.

Someone places a microphone before him and asks that he, an American doctor, an American medical officer, say a word to the American people. Could they be asking him, a kid who only a few months ago was merely an intern? Yes, that's right—so as tired as he is, he steps forward and speaks crisply, distinctly, and with a voice used to giving commands under stress and having them obeyed:

"Hey, you! and you, and you,
We've still got a war to win.
I can stick it out.
Can you?"

Can we?

THOMAS A. HENDRICKS,
Executive Secretary.

TREASURER

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The accompanying report prepared by the George S. Olive Company, certified public accountants, gives our financial statement for the period ending December 31, 1943. In April, 1944, three of the \$1,000 United States Treasury Bonds held in our Medical Defense Fund were called. Since then the amount has been reinvested in series G War Bonds.

As was anticipated when our present budget was made up, we will show a deficit this year. The total amount of this deficit will not be known until the end of the year. Some of this is accounted for by the fact that your organization pays out \$2.75 for each member in the service. With 940 members in the service paying no dues, this leaves about 2,200

members meeting expenses. It has been suggested that we take steps to increase our revenue. This can be accomplished in any of three ways: Increase membership dues, levy special assessment, or cut down on expenses. It is also suggested that we should have added funds to take care of possible post-war plans.

A. F. WEYERBACHER, M.D.,
Treasurer.

EXHIBIT A

Indiana State Medical Association

ANALYSIS OF DECREASE IN ASSETS, ALL FUNDS,
YEAR ENDED DECEMBER 31, 1943

TOTAL ASSETS, DECEMBER 31, 1943—Exhibit B.....	\$53,145.85
TOTAL ASSETS, DECEMBER 31, 1942.....	59,892.70
NET DECREASE	\$ 6,746.85

Arising from the following sources:

Excess of operating cash disbursements over operating cash receipts, general fund, year ended December 31, 1943:	
Receipts—Exhibit C	\$30,077.97
Disbursements—Exhibit C.....	35,921.30
Excess of operating disbursements	\$5,843.33
Excess of operating disbursements over operating receipts, THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1943:	
Receipts—Exhibit D	\$19,334.88
Disbursements—Exhibit D.....	20,654.40
Excess of operating disbursements	1,319.52
Excess of operating receipts over operating disbursements, medical defense fund, year ended December 31, 1943:	
Receipts—Exhibit E.....	\$ 2,761.75
Disbursements—Exhibit E.....	2,345.75
Excess of operating receipts	416.00
Total Net Decrease.....	\$ 6,746.85

EXHIBIT B

STATEMENT OF ASSETS, ALL FUNDS,
AT DECEMBER 31, 1943

General Fund:

Cash on deposit—Exhibit C.....	\$ 5,131.81
Petty cash fund.....	200.00
Investments:	
Marion County Flood Prevention bonds	\$ 3,000.00
Indianapolis City Hospital bonds	5,000.00

U. S. Treasury bonds.....	13,000.00
U. S. Savings bonds.....	5,000.00
	26,000.00
Total general fund assets	\$31,331.81

The Journal of The Indiana State Medical Association:

Cash on deposit—Exhibit D....	1,385.82
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Medical Defense Fund:

Cash on deposit—Exhibit E....	5,428.22
Investments:	
Marion County Flood Prevention bonds	\$ 2,000.00
U. S. Treasury bonds.....	8,000.00
U. S. Savings bonds.....	2,000.00
U. S. Baby bonds.....	3,000.00
	15,000.00
	20,428.22

Total Assets, All Funds—Exhibit A.....	\$53,145.85
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EXHIBIT C

COMPARATIVE STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEARS ENDED DECEMBER 31, 1943,
AND DECEMBER 31, 1942

	Year Ended Dec. 31, 1943	Dec. 31, 1942	Increase Decrease
CASH BALANCE AT BEGINNING OF YEAR	\$10,975.14	\$12,637.06	\$1,661.92
Receipts:			
Membership dues	23,132.00	29,621.83	6,489.83
Income from exhibits	5,455.00	3,027.50	2,427.50
Petty cash refund—contra.....	300.00		300.00
Miscellaneous refunds	45.50	1.88	43.62
Beachton Court Liquidation Trust distribution	35.80	1,815.60	1,779.80
Rokeby Liquidation Trust distribution		307.20	307.20
Refunds of traveling expense..		222.84	222.84
Interest income:			
U. S. Treasury bonds.....	368.75	368.75	
U. S. Savings bonds.....	87.50	25.00	62.50
Indianapolis, Indiana, City Hospital bonds	200.00	200.00	
Marion County, Indiana, Flood Prevention bonds.....	127.50	127.50	
Instruction courses — annual session	169.25		169.25
Refund on 1942 convention.....	156.67		156.67
Total receipts	\$30,077.97	\$35,718.10	\$5,640.13
BEGINNING BALANCE PLUS CASH RECEIPTS	\$41,053.11	\$48,355.16	\$7,302.05
Disbursements:			
Transfer of applicable portion of dues to THE JOURNAL of The Indiana State Medical Association—Exhibit D	6,638.00	6,494.50	143.50
Medical defense fund — Exhibit E	2,414.25	2,364.75	49.50
Headquarters' office expense..	10,608.60	10,680.74	72.14
Publicity committee	394.96	250.81	144.15

Public policy	1,973.40	220.71	1,752.69
Council	6,153.25	6,265.60	112.35
Officers	521.20	439.35	81.85
Rent	500.00	500.00	
Annual session	4,049.86	1,995.22	2,054.64
Miscellaneous committees	1,996.07	1,404.67	591.40
Post-graduate study		15.50	15.50
Federal O. A. B. tax	64.21	60.67	3.54
Military dues refunds	282.50	1,590.00	1,307.50
Petty cash refund—contra	300.00		300.00
Other refunds	25.00	25.00	
Securities purchased		5,000.00	5,000.00
Sundry		72.50	72.50
Total disbursements	\$35,921.30	\$37,380.02	\$1,458.72
Cash Balance at End of Year	\$ 5,131.81	\$10,975.14	\$5,843.33
(Exhibit B)			

EXHIBIT D

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS,
YEAR ENDED DECEMBER 31, 1943THE JOURNAL OF THE INDIANA STATE MEDICAL
ASSOCIATION

BALANCE, JANUARY 1, 1943..... \$ 2,705.34

Receipts:

Subscriptions—members—Exhibit C	\$ 6,638.00
Subscriptions—non-members	571.43
Advertising	11,964.93
Collection on accounts receivable	75.00
Single copy sales	24.00
Electrotypes	61.52
Total receipts—Exhibit A	19,334.88
	\$22,040.22

Disbursements:

Editorial and management salaries	\$ 8,387.99
Printing	9,515.47
Office postage	165.00
Journal postage	465.68
Press clippings	70.97
Electrotypes	594.28
Office rent and light	247.62
Office supplies	578.56
Advertising commissions and reporting	418.49
Federal O. A. B. tax	58.37
Expenses—editor and editorial board	50.41
Sundry	101.56
Total disbursements—Exhibit A	20,654.40

Balance, December 31, 1943—Exhibit B..... **\$ 1,385.82**

EXHIBIT E

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS,
YEAR ENDED DECEMBER 31, 1943

MEDICAL DEFENSE FUND

BALANCE, JANUARY 1, 1943..... \$5,012.22

Receipts:

Transfer of applicable portion of dues from the general fund—Exhibit C	\$2,414.25
Interest income:	
U. S. Treasury bonds	\$237.50
U. S. Savings bonds	25.00
Marion County, Indiana, Flood Prevention bonds	85.00
	347.50
Total receipts—Exhibit A	2,761.75
	\$7,773.97

Disbursements:

Attorney's fee	\$1,800.00
Malpractice fees	500.00
Treasurer's bond	15.00
Printing	30.75
Total disbursements—Exhibit A	2,345.75
Balance, December 31, 1943—Exhibit B	\$5,428.22

CHAIRMAN OF THE COUNCIL

House of Delegates,

Indiana State Medical Association.

Gentlemen:

Reports of the Council meetings during the past year have been published in the November, 1943, and the February, 1944, issues of THE JOURNAL. Therefore your chairman at this time presents merely a brief summary of some of the outstanding matters which have been discussed and the actions taken by the Council.

FIRST MEETING, INDIANAPOLIS, SEPTEMBER 28, 1943

The roll call showed twelve councilors present when the meeting was called to order by Dr. Floyd T. Romberger, chairman, at 12:30 P. M., in Parlor B, Claypool Hotel, Indianapolis. In addition to the councilors, the members of the Executive Committee, a member of the Board of Trustees of the American Medical Association, delegates to the A. M. A., and various committee chairmen were present.

Councilor reports as printed in the September, 1943, issue of THE JOURNAL and the *Handbook of the House of Delegates* were accepted unanimously.

Report on Group Malpractice Insurance

Dr. Cleon A. Nafe, chairman of the Executive Committee, made a report to the Council upon behalf of the Executive Committee, recommending group malpractice insurance to the members of the state association. The report stated that the

cost of malpractice insurance had increased considerably in the last several years, particularly in metropolitan areas; that complaints had been received in regard to the limitations of coverage by several companies; that approximately sixteen state associations and many individual county associations have group malpractice policies in force, and that a more adequate group policy could be written than is obtained by individual physicians. The report was referred by the Council to the House of Delegates.

Emergency Maternal and Infant-Care Program

Dr. H. F. Nolting, chairman of the Advisory Committee to the Bureau of Maternal and Child-Health of the Indiana State Board of Health, Dr. Thurman B. Rice, State Health Commissioner, and Dr. R. E. Jewett, director of the Bureau of Maternal and Child-Health of the State Board of Health, appeared before the Council and discussed this question. A special room was set aside at the Claypool Hotel for Dr. Nolting and his committee to hold hearings upon the EMIC program, and a special reference committee was appointed to handle all questions concerning this matter which came before the House of Delegates.

Report of Editor of THE JOURNAL

Dr. E. M. Shanklin, editor, reported that publication costs of THE JOURNAL, both printing and employment, were increasing.

The Council instructed the Executive Committee to contract for publication of THE JOURNAL for the coming year.

The Council voted not to accept liquor advertisements during 1944.

Announcement was made that Dr. Shanklin recently had been appointed on the Advisory Committee of the Cooperative Medical Advertising Bureau of the American Medical Association.

JOURNAL Staff Elections

Dr. E. M. Shanklin was re-elected unanimously as editor of THE JOURNAL for 1944.

Dr. M. A. Austin and Dr. Minor Miller were elected members of the Editorial Board to serve for three years.

Membership Problems

The Council discussed the fact that owing to the neglect of county society secretaries many men in service have been deprived of membership in the state association. Report was made that while there are 1,180 physicians in service, only 800 had been certified to the secretary's office.

New Council on Medical Service and Public Relations

Dr. R. L. Sensenich, member of the Board of Trustees of the American Medical Association, discussed the formation of the new Council on Medical Service and Public Relations.

Medical Care for Migrant Workers

Dr. F. S. Crockett, of Lafayette, discussed the organization in a number of states to take care of this problem.

SECOND MEETING, INDIANAPOLIS, SEPTEMBER 30, 1943

Immediately upon adjournment of the House of Delegates, the second meeting of the Council was called, with Dr. Floyd T. Romberger presiding. Roll call showed nine councilors present, along with the officers of the state association and members of the Executive Committee.

Public Relations

The problems confronting the association in regard to public relations were discussed and the final authority for the arrangements of the Public Relations Program was left with the Executive Committee, and the matter was to be referred back to the Council at the midwinter meeting.

MIDWINTER MEETING, INDIANAPOLIS, JANUARY 9, 1944

The Council was called to order by Dr. Floyd T. Romberger, of Lafayette, chairman, at 10:10 A. M., January 9, 1944, at the Columbia Club, Indianapolis. Roll call showed all thirteen councilors, the officers, and members of the Executive Committee of the state medical association present.

Reports by Districts

Each councilor made a brief report of the activities of his district. Dr. N. K. Forster, president-elect, introduced Dr. William H. Howard, of Hammond, new councilor of the Tenth District, and Dr. Cleon Nafe introduced Dr. Walter L. Portteus, of Franklin, president of the Seventh District Medical Society, who is serving as councilor of the Seventh District in the absence of Colonel C. J. Clark.

Dr. A. P. Hauss, councilor for the Third District, gave a comprehensive report on the questions coming before the Third District Medical Society.

Dr. Romberger, councilor of the Ninth District, spoke of the *Courier-Journal* spread in regard to the Wagner-Murray-Dingell Bill.

Dr. Alfred Ellison spoke of the annual Thirteenth District meeting with an attendance of four

hundred, at which Sister Elizabeth Kenny was the principal speaker.

Reports of Officers

Short reports were made by Dr. J. T. Oliphant, president in 1944; Dr. N. K. Forster, president-elect; Dr. C. H. McCaskey, president in 1943; Dr. E. M. Shanklin, editor of *THE JOURNAL*, and Dr. A. F. Weyerbacher, treasurer.

Dr. Oliphant made the recommendation of a medical service plan as a "must" for consideration of the 1944 meeting of the House of Delegates.

The treasurer's report showed that the association was operating with a loss of \$6,746.85, due to the loss of revenue formerly received from physicians who are now in the armed forces.

Plan to Carry Out Action of House of Delegates

Dr. Cleon Nafe, chairman of the Executive Committee, presented a program of the Executive Committee to the Council to carry out the mandate of the House of Delegates. This plan was suggested:

- (1) Increased personnel in headquarters office.
- (2) Inauguration of radio broadcasts by Bureau of Publicity.
- (3) Additional clerical help for Procurement and Assignment Service.
- (4) Increase of present employees' salaries.
- (5) Increase in state dues from \$10.00 to \$15.00 per year to make up for loss of revenue because of men in military service.

Hospital Insurance

Dr. McCaskey made a report upon the formation of a mutual hospital insurance company by the Indiana Hospital Association. He reported that members of the Executive Committee were keeping in touch with this development.

Plans for 1944 Annual Session

A preliminary report upon the proposals and suggestions for the 1944 annual session, to be held in Indianapolis, October 3, 4 and 5, was presented to and approved by the Council. This plan calls for a streamlined war meeting, with the final scientific meeting on Thursday morning eliminated, along with the golf tournament and trap shoot. It calls for an intensification of the instructional courses which were started with the 1943 meeting. The meeting is to be held in conjunction with the Medical Services of the Army Air Corps.

Contract with Editor of *THE JOURNAL*

This contract was renewed for 1944.

Nominations for Editorial Board

Drs. Charles N. Combs, Terre Haute; F. R. N. Carter, South Bend; Bert Ellis, Indianapolis, and Lall G. Montgomery, Muncie, were nominated. Two places are to be filled on the Editorial Board at the first meeting of the Council on October 3, 1944, to replace Drs. James O. Ritchey, Indianapolis, and Robert V. Hoffman, South Bend.

Elections for 1944

Dr. C. A. Nafe and Dr. C. H. McCaskey were elected members of the Executive Committee for 1944.

Dr. Floyd T. Romberger was unanimously re-elected chairman of the Council for 1944.

Luncheon Meeting

During the luncheon meeting reports were made by the following committee chairmen and guests: Dr. Alfred Ellison, medical relief problems; Dr. H. G. Hamer, chairman, Bureau of Publicity, radio program; Dr. R. L. Sensenich, member of Board of Trustees, A. M. A., national legislative matters; Dr. Charles R. Bird, chairman, Procurement and Assignment Service for Indiana.

Appreciation of Dr. E. O. Asher

The Council expressed its deep appreciation for the service rendered by Dr. E. O. Asher, who served as a member of the Executive Committee for two and one-half years. Illness has prevented Dr. Asher's active participation as a member of the committee within recent months. The Council hopes for his early and complete recovery.

FLOYD T. ROMBERGER, *Chairman*.

REPORTS FROM DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

A joint meeting of the First District Medical Society and the Vanderburgh County Medical Society was held in the Vendome Hotel, in Evansville, on June 13, 1944. The guest speaker was Dr. Harry L. Alexander, Professor of Clinical Medicine at the Washington University Medical School. His subject was "Diagnosis and Treatment of Chronic Arthritis." The following officers were elected: president, Dr. A. F. Marchand, Haubstadt; vice-president, Dr. William M. Cockrum, Evansville;

secretary-treasurer, Dr. George Willison, Evansville; councilor, Dr. I. C. Barclay, Evansville.

I. C. BARCLAY, M.D., *Councilor*

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SECOND COUNCILOR DISTRICT

Another year of war behind us. Physicians are twelve months older in years, but many months older in wear and tear. Our government takes our district medical graduates, but does not give back to us any of the limited-service or returned-from-active-service M.D.'s.

There is a general feeling among the members of the district society that the government, the medical schools, and medical organizations are not planning ahead *far enough* nor *well enough* to care, properly, for the public in the next five or ten years.

Second District hospitals are functioning. There is many a squeak and squawk but the wheels revolve. Individuals and families who enjoyed the past ward rates and general nursing, now that they have money, can not understand why there are no private rooms or private nurses. Everybody carries on.

I can not help but recall what happened to the "One-Horse Shay."

H. C. WADSWORTH, M.D., *Councilor*

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THIRD COUNCILOR DISTRICT

The Third District Medical Society will meet on Wednesday, September twentieth, at New Albany, with the Floyd County Medical Society acting as host. The meeting will be held at Silvercrest (Southern Indiana Tuberculosis Hospital), the state's newest and finest hospital, located in the beautiful Silver Hills adjacent to New Albany.

This will be the first meeting of the district society since May, 1942, and a large attendance is expected. Dr. Henderson L. Miller, of West Baden, is the hold-over president, and Dr. George Dillinger, of French Lick but now in the armed forces, is the district secretary.

A splendid scientific program will be presented, and the program will include a noon dinner at Silvercrest, with Dr. J. V. Pace, superintendent, as host. Special guests will include President Jacob T. Oliphant, M.D., of Farmersburg; President-elect N. K. Forster, M.D., of Hammond, and Executive Secretary Thomas A. Hendricks, of Indianapolis, officers of the Indiana State Medical Association.

AUGUSTUS P. HAUSS, M.D., *Councilor*

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FOURTH COUNCILOR DISTRICT

Most of the component societies held fewer meetings this year; some held meetings only at irregu-

lar intervals. The attendance was smaller in number, but interest in medical matters was as keen as ever.

Interest of the laity in legislative matters pertaining to medical practice is becoming more apparent as numerous requests for speakers at lay-group meetings are being received.

Our district meeting at North Vernon, May twenty-fourth, was streamlined to a scientific session only. We had a good program and a fair attendance. Dr. Thurman Rice represented the State Board of Health, and Thomas A. Hendricks represented the Indiana State Medical Association.

Captain George A. May, of Madison, was elected president for 1945; Dr. Robert B. Hart, of Columbus, vice-president; and Dr. Oscar A. Turner, of Madison, secretary-treasurer. Dr. Charles Overpeck, of Greensburg, was elected councilor for the term 1945-1949. The next meeting will be held at Madison in May, 1945.

J. C. ELLIOTT, M.D., *Councilor*

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FIFTH COUNCILOR DISTRICT

The Fifth District Medical Society has not held a meeting for some time due to the fact that the president and the secretary are in the armed forces and in foreign service, and the vice-president is ill and in a hospital. However, even during the stress of war, each individual society is functioning very satisfactorily.

We hope that we can have a meeting of the district society this fall for the election of officers and the rehabilitation of the organization.

A. M. MITCHELL, M.D., *Councilor*

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SIXTH COUNCILOR DISTRICT

The Sixth District Medical Society met in Greenfield on Thursday, May eighteenth. The meeting was well attended, and the program was very interesting.

The following officers were elected: president, Dr. W. A. Thompson, of Liberty; vice-president, Dr. W. U. Kennedy, of New Castle; and secretary-treasurer, Dr. J. E. Ferrell, of Fortville.

Rushville was selected as the meeting place for next year.

SAMUEL KENNEDY, M.D., *Councilor*

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SEVENTH COUNCILOR DISTRICT

The Seventh District Medical Society held its fall meeting at Martinsville, as guests of the Home Lawn Sanitarium. I was elected president of the district, and by virtue of that office will be *councilor*

pro tem of the Seventh District. Dr. L. H. Kornafel was re-elected secretary-treasurer, and Dr. Charles Weller was named president.

The evening meeting was held at the Martinsville Country Club. Three veterans from Billings General Hospital entertained the members with an account of their war experiences.

The spring meeting was held in Indianapolis, with that society being host to the Seventh District. Papers were read on "Penicillin," by members of the Billings General Hospital.

This fall, Franklin will play host to the Seventh District Medical Society.

W. L. PORTEUS, M.D., *Councilor pro tem.*

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EIGHTH COUNCILOR DISTRICT

Each county society in the Eighth District has continued regular meetings, and with much interest.

The district had but one meeting since our last report. This meeting was held at Anderson, in the Y.M.C.A. building, May 29, 1944. The afternoon session was presided over by the president, Dr. C. A. Ball. The activities of the state committee on hospital insurance were discussed by Dr. Ball, and the purposes of and the work done by the committee and the insurance company for hospital and medical care were discussed by Dr. Bruce Stocking. Dr. Stocking is a member of the board of directors. Dr. Morris Fishbein, who was our guest, related the experiences of the American Medical Association office with the hospital insurance plan.

The following officers were elected for the coming year:

Dr. C. E. Martin, President.

Dr. I. E. Brønner, Secretary-Treasurer.

Dr. E. H. Clauser, re-elected Councilor.

In the evening the group attended a public meeting sponsored by the Woman's Auxiliary of Madison County, at which Dr. Morris Fishbein discussed the undesirable features of the "Wagner-Murray-Dingell Bill." This meeting was very well attended.

E. H. CLAUSER, M.D., *Councilor*

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NINTH COUNCILOR DISTRICT

The 1944 District Meeting was held at Crawfordsville, May twenty-fourth, with the Montgomery County Medical Society as host. It was one of the most interesting meetings ever held. For its success great credit must be given to President Wemple Dodds and his able committees.

Of unusual attractiveness and interest was the Clinical Pathological Conference held at the afternoon session, and a real highlight was Dean W. D. Gatch's address upon the subject of "Lay Domination of Medical Practice."

The 1945 meeting will be held in Noblesville at a time to be determined later.

FLOYD T. ROMBERGER, M.D., *Councilor*

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TENTH COUNCILOR DISTRICT

The Tenth District Medical Society seems to be working hard, and to have its affairs in good order.

Dr. John R. Frank, of Porter County, reports that they are having some meetings, and that the county society is in good condition.

Dr. W. G. Pippenger, secretary of the Jasper-Newton County Medical Society, says they are not having stated meetings but that their business is taken care of at the hospital meetings, which convenes as the medical society.

The Lake County Medical Society continues its constant vigilance over and active participation in all affairs concerning medicine and health in its bailiwick. The society's committees and branches have not met as frequently as before the war, but its public relations policies had already been so well established that the officers, council, and committee chairmen can act upon most problems in accordance with the previously-established principles and without calling special meetings of its already over-burdened members.

The executive secretary recently summed up these principles in an answer to the question of a member of the society's council: "Whenever I am confronted with a problem in which there can be no doubt regarding the solution that will result in the greatest advantage to the public health or the individual patient, I know the decision of the Society and its officers before I ask. In no instance have I ever seen the public health or the interests of the individual patient sacrificed in favor of the interests of the Society or its members."

W. H. HOWARD, M.D., *Councilor*

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ELEVENTH COUNCILOR DISTRICT

All counties in the Eleventh Councilor District are well organized and hold regular meetings. With the passing of Dr. E. H. Brubaker, of Flora, Carroll County is extremely hard hit. We continue to hold spring and fall meetings in our—the best—district in the state, but the programs are limited to the afternoon scientific session. The next meeting will be held in Kokomo, October 18, 1944.

At our last meeting, which was held in Wabash, May seventeenth, Dr. Perry resigned as councilor, and Dr. C. S. Black, of Warren, was unanimously elected to fill Doctor Perry's unexpired term, which extends to January 1, 1946.

O. G. BRUBAKER, M.D., *Secretary*

TWELFTH COUNCILOR DISTRICT

The councilor's report from any district in the United States for 1944 could read like this:

"Every doctor in the District is working like h—. In spite of this he attends meetings—on wartime basis—and keeps up with new developments in medicine. He is neglecting his own health but doing a swell job for his community.

"He is thoroughly aware of the bureaucrats' efforts to federalize medical practice. But, in spite of repeated warnings that organized medicine will have to combat it through local or district action, it is difficult to arouse sufficient interest to attack this problem."

Can anyone suggest a nicer homecoming present for the doctors in service than a reasonable solution for the latter problem by those at home now?

A. JEROME SPARKS, M.D., *Councilor*

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THIRTEENTH COUNCILOR DISTRICT

The affairs of the Thirteenth District Medical Society are in good condition. At our annual meeting this spring we were addressed by President-Elect, Dr. Herman L. Kretschmer, of Chicago, who talked on "Urinary Tract Infections in Women and Children." The meeting was well attended. The Indiana State Medical Association was represented by Dr. N. K. Forster, president-elect.

Many of our members have remarked about the frequency with which representative national lay magazines are publishing articles favoring socialized medicine. The members are wondering if it will not be possible for our profession to have its side of the case presented likewise.

ALFRED ELLISON, M.D., *Councilor*

COMMITTEE ON CREDENTIALS

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The Committee on Credentials has nothing to report at this time.

In accordance with the Constitution and By-Laws of the Indiana State Medical Association, each county medical society must certify its delegates and alternates previous to the annual session of the state association. A postal card notification signed by the secretary of the local county medical society and sent to the headquarters office is sufficient

certification. If you have not yet taken this action in your society, we urge that this be done immediately.

W. E. AMY, M.D., *Chairman,*

J. R. CROWDER, M.D.,

A. E. STINSON, M.D.,

S. C. DARROCH, M.D.

EXECUTIVE COMMITTEE

House of Delegates,

Indiana State Medical Association.

Gentlemen:

I. THREE-POINT PROGRAM.

At its session a year ago the House of Delegates laid down a three-point program, and it has fallen largely to the Executive Committee to do the work of carrying out this program which provided for the establishment of:

1. Better public relations;
2. Hospital and medical service plans;
3. Group malpractice insurance for the members of the association.

1. **Demand for better public relations** has been the keynote during the past year. Wherever doctors get together, whether it be at an impromptu meeting in the physicians' room of a hospital or at the annual session of the American Medical Association, the theme of the conversation has nearly always been the same, "Why can't we have better public relations?" In Indiana this demand has been no less urgently expressed than in other states, a demand which has resulted in the formation of committees within the regular medical organization, such as the recently-formed Council on Medical Service and Public Relations of the American Medical Association, and outside of the organization, by the creation of groups such as the National Physicians Committee, the Association of American Physicians and Surgeons in Lake County, and the United Public Health League composed of a group of western states. The impelling motive that brought each of these groups into being was generally a demand for a more aggressive, active voice of the profession in economic and political matters. The members of the House of Delegates of the Indiana State Medical Association expressed this emphatically and specifically at the 1943 session in regard to the subject of public relations and medical economics, and immediate steps were taken by your officers and the members of the Executive Committee to fulfill as completely as possible the desires of the House of Delegates. Speakers were prepared

and supplied to talk upon the Wagner-Murray-Dingell Bill, radio programs were instituted, and many public meetings were held. The end result has been that probably more radio programs in regard to health, sponsored by medical societies, have been given over Indiana stations since the first of the year than have been broadcast over the stations of any other state. More public meetings for the discussion of the Wagner-Murray-Dingell Bill were held last year than ever before in the history of Indiana Medicine, and more physicians took an active part in discussing, before the public, broad economic problems than ever before. The definite duty of doing this job fell upon the shoulders of the Bureau of Publicity, and we call your attention to the detailed report covering most of the activities in regard to public relations during the year.

On the national front the battle to bring about a realization that much needs to be done in the field of public relations by the American Medical Association has not been an easy one. A start was made a year and a half ago by the House of Delegates of the American Medical Association in the creation of a Council on Medical Service and Public Relations.

The Executive Committee therefore recommends that this House of Delegates go on record at this time commending the efforts of the new council and urging the American Medical Association to give its full support, moral and financial, in order that this new council may be allowed to do the job that the rank and file of the profession expect it to do.

Here in Indiana a start has been made upon a program of public relations, and it is up to the House of Delegates now to decide whether or not it desires a continuance and expansion of this endeavor in the field of public relations.

2. Hospital and Medical Service Plans.

(a) *Blue Cross Hospital Plan.* Many have been the meetings and long have been the hours of discussion upon the intricate problems that arise in perfecting plans for the establishment of hospital and medical service plans in this state. A Blue Cross hospitalization plan has already been established under the title of Mutual Hospital Insurance, Inc., 544 Consolidated Building, Indianapolis, Indiana, with Guy W. Spring as executive director. Mr. Spring comes to Indiana from Cincinnati, Ohio, where he has been connected with the Blue Cross Hospital Plan. Two Indiana physicians are serving on the board of trustees and are numbered among the incorporators of this plan.

The various problems having to do with radiology and pathology have been discussed by the committee, and at least tentative agreements have been reached by the committee concerning procedures and practices in this field as they concern patients receiving services under this plan.

(b) *Medical Service Plan.* The House of Delegates specifically recommended that a medical serv-

ice plan be presented for its consideration at the 1944 session. The duty of working out this plan was given to the Permanent Study Committee on Health Insurance, of which Dr. W. H. Howard, of Hammond, is chairman. You are referred to Dr. Howard's committee for detailed report upon this program.

3. **Group malpractice insurance.** The St. Paul Mercury Indemnity Company has been officially designated as the underwriter for group malpractice insurance by your committee. The selection of this company was made in accordance with the instructions from the House of Delegates that such arrangements be made with an insurance company. Your committee has spent much time and effort in arriving at its decision in recommending this company to you. Letters were sent to each insurance company asking whether or not each would be interested in writing this type of insurance. Several widely-known companies said they were not interested in submitting a group policy. However, four well-established companies replied that they would be interested. Conferences then were held with each of these companies with the result that your committee recommends the St. Paul Mercury Indemnity Insurance Company as offering the type of basic group policy which best suits the purposes of the physicians of Indiana. Announcements by the St. Paul Mercury Indemnity Company appear in the September issue of *THE JOURNAL*.

II. SPECIAL AND REGULAR ADMINISTRATIVE FUNCTIONS OF THE EXECUTIVE COMMITTEE.

As it has been since Pearl Harbor, the main effort of the committee has been to win the war as completely and as soon as possible. We are all deeply proud of the fact that 1,260 Indiana physicians are serving in the armed forces. The committee also appreciates the task done by the doctors of Indiana on the home front, most of whom are working literally day and night to take care of the civilian population. Of course, the many usual problems and routine duties seem to have multiplied rather than lessened during the war, in addition to the several all-important special emergency chores which face the profession, the most outstanding of which already have been discussed. In general, these regular duties of the committee fall into three parts:

- A. Administrative.
- B. Management of *THE JOURNAL*.
- C. Administration of medical defense fund.

A. ADMINISTRATIVE.

1. **Monthly meetings of the committee.** In addition to the regular monthly meetings of the committee, innumerable informal meetings and conferences have been held. At nearly all of the regular meet-

ings the chairmen and members of some of the key committees or administrative groups of the association have been invited to lunch with the committee and discuss various individual problems. These joint meetings have been held with such key committees as the Bureau of Publicity, the Permanent Study Committee on Health Insurance, OPA Medical Advisory Committee, chairmen of the Legislative Committee, Advisory Committee to the Bureau of Maternal and Child-Health of the Indiana State Board of Health, the newly-formed Committee on Lay Activity in Medical Practice, representatives of the Indiana Roentgen Society and the pathologists, the Blue Cross hospital group, and officers of societies, et cetera.

2. Membership. After a drop in membership last year for the first time in ten years, the membership figures again show an increase for 1944, and now stand at the highest in the association's history. A comparison of the figures for 1942, 1943 and 1944 follows:

Year	Number of Physicians in Indiana	Regular Members	Honorary Members	Total Members
1942.....	4,132	3,081	110	3,191
1943.....	4,165	2,983*	110	3,093
1944.....	4,165	3,197**	129	3,330

* Includes 741 men in service who received membership gratis.

** Includes 936 men in service who received membership gratis.

3. Wartime annual sessions. The Indiana State Medical Association has established a sound reputation for its wartime sessions. Last year the ninety-fourth annual session was held in conjunction with the Ninth Naval District. The medical services of the Air Forces, headed by Major General David N. W. Grant, Air Surgeon, will cooperate in the meeting this year, the ninety-fifth annual session of the Indiana organization.

The 1943 convention issue of THE JOURNAL was dedicated to the Navy Medical Corps. This year's convention issue is published in honor of the Air Corps.

For the privilege of holding these two meetings in conjunction with these two branches of the armed forces and for their all-out cooperation we take this opportunity to express our sincere appreciation and to thank Admiral Ross T. McIntire, Surgeon General of the Navy, and General David N. W. Grant and their staffs.

4. Food rationing for the sick. Your attention is called to the effective work being done by the OPA Medical Advisory Committee, with Dr. C. L. Rudesill as chairman. Realizing the tremendous importance of this rationing problem for the sick, at the request of the state OPA officials, the Executive Committee early set up a special committee to advise with the OPA in regard to food rationing. It is gratifying to know that the principles worked out by this committee for the food rationing pro-

gram for the sick, in conjunction with the Indiana OPA officials, have been the basis for plans adopted throughout the nation for rationing food for sick persons. We call your attention to the report of this committee and ask your cooperation. We wish to express the appreciation of the Indiana State Medical Association for the spirit in which James Strickland, district director of OPA, and Paul Moore, state food rationing officer of OPA, went about in solving this problem, and for their complete understanding of the difficult situation faced by the doctors at this time of national crisis.

5. EMIC program. Probably the care of servicemen's wives and children has caused more discussion than any problem facing the profession outside of the Wagner-Murray-Dingell Bill during the past year. Many meetings and conferences upon problems arising from this program have been held in Indiana. A special meeting to discuss this program was called on April 28 and 29 by a group of ten western states, to which Indiana was invited. Resolutions from this group were presented to the American Medical Association and sent to the congressmen from these ten states. Spokesmen for the American Medical Association appeared at the congressional committee hearing in Washington in April. No one seems opposed to the purpose of the Act. Practically everyone except the Children's Bureau seems very much opposed to the methods of administration. It is hoped that in the future such programs will not be undertaken without giving the spokesmen of the medical profession full chance to express their viewpoint. As such programs can be carried out only by the doctors, they should have a part in writing the rules of procedure and should have a hand in directing the program. In the past, as administered by the Children's Bureau, there has been too much of a hard-boiled "take it" or "leave it" attitude. For the present it looks as if, as a result of congressional hearings, some of the red tape in the program may be cut, but that the practice will be continued whereby the funds will be paid to the doctor and not to the patient as advocated by the American Medical Association.

6. Mass x-ray tuberculosis program. Some months ago representatives of the State Board of Health and representatives of the Roentgen Ray Society, along with the chairman of the Anti-Tuberculosis Committee of the Indiana State Medical Association, met with the Executive Committee and discussed the possibility of the State Board of Health making a mass x-ray industrial survey in Indiana through a representative of the United States Public Health Service. The Executive Committee declined to approve a plan whereby this survey would be made by the United States Public Health Service. Since that time the Indiana Tuberculosis Association and representatives of the Indiana Roentgen Society have worked out a plan whereby

these industrial surveys are to be made under the sponsorship of the Indiana Tuberculosis Association. Your committee understands that the Roentgen Ray Society, the Anti-Tuberculosis Committee of the state medical association, and the Indiana Tuberculosis Association are all agreed upon the program which is being presented to each county medical society by the local tuberculosis groups. Your committee understands further that these surveys are to be undertaken only where the county medical societies give their approval. It is understood that this survey is merely to screen out those in industry who have tuberculosis, and that it is not at all definitive and no diagnosis is made. Those whose films indicate tuberculosis are directed to go to their family doctor and get under medical care immediately. Surveys are under way in several counties with the approval of the local medical society.

7. Program of the Indiana State Board of Health.

Under the direction of Dr. Thurman B. Rice, the Indiana State Board of Health has presented a far-sighted and comprehensive postwar program. This program, so far-reaching and involving so many factors, is not designed to be carried out over night. Copies of the detailed program have been sent to each councilor and to each member of the Executive and Legislative committees of the state association. Articles have appeared in *THE JOURNAL*, and a joint meeting of the Executive Committee, where this program was outlined, was held with members of the State Board of Health on July 16.

In brief, the program provides for the following five points:

- (1) Recodification of Indiana health laws.
- (2) Reorganization of Indiana State Board of Health.
- (3) Division of state into health districts on a full-time basis.
- (4) Construction of new health department buildings.
- (5) Organization of a School of Public Health at the Indiana University School of Medicine.

A special reference committee will be appointed by President Oliphant to which this program and all matters and questions and resolutions pertaining to the State Board of Health are to be referred. A special room will be set aside where physicians may discuss this plan, the EMIC program, and other questions relative to the State Board of Health, with the health officials themselves.

Consideration of this postwar program in all its numerous phases is one of the most important matters to come before the House for consideration.

8. State council of social agencies proposed. A state-wide meeting to discuss the problem of juvenile delinquency was held several months ago at Purdue. A movement to create a state council of

social agencies which would concern itself with matters of health, education, welfare and safety resulted from this conference. The Indiana State Medical Association was invited to sit in on a conference called by representatives of the four state-supported institutions of higher learning, where the creation of such a council was discussed. A sub-committee was formed to bring in a definite program for such a council, and by the time of the Indiana State Medical Association meeting in October this program should be available for study and comment.

Although many cities have local councils of social agencies, there is no state council. These local councils generally have gained a reputation for effective service. A state council might be of value if it did not become a sounding board upon which the social service groups advocating socialized medicine could bring attention and attempt to arouse public sentiment for the regimentation of medicine.

A suggestion was made that perhaps this council could be part of the Social Service Conference. Physicians would be slow to approve such an alliance due to the fact that the Social Work Conference this year is showing such remarkable interest in the Wagner-Murray-Dingell Bill. Why this legislation, which is looked upon as "dead" by the congressional committees to which it has been referred, should have such a prominent place on the social workers' program when so many urgent war problems are pressing is difficult for physicians to understand.

9. Separate medical organizations. The Executive Committee feels that separate organizations such as the National Physicians Committee, the Association of American Physicians and Surgeons (Lake County), the United Public Health League (outgrowth of the Western States Public Health League) are each doing a job which should be done by the American Medical Association. Hence, these groups have received no official recognition from the Executive Committee. The committee has taken the stand that it is the privilege of each doctor to decide whether or not he wants to participate and lend his support to these groups. Perhaps the House may desire to clarify this stand.

10. Establishment of a Washington office. Closely connected with the subject of public relations and the development of separate medical organizations is the question of the establishment of a Washington office for the American Medical Association. For the last two years resolutions from many state societies have voiced this demand. The Indiana State Medical Association has been among those states which have advocated the establishment of a "real" Washington office for the medical profession. We understand that at the present time both the United Public Health League and the new Public Relations Council of the American Medical

Association have established offices in Washington. The AMA office is at 900 Columbia Medical Building, 1835 I Street, N.W., Washington 6, D.C., but when this report was written no director had been named. Apparently strong opposition to the establishment of a Washington office still exists among the officials of the American Medical Association despite the expressed will of the majority of the state medical associations upon this question, and your committee feels that no effective Washington office can be established nor the public relations job done, which the profession hopes to have done, as long as the opposition from the American Medical Association exists.

11. Indiana Contact Plan. At the suggestion of Dr. R. L. Sensenich, past president of the state association and a member of the Board of Trustees of the American Medical Association, the "Indiana Contact Plan" which was originated in 1934, was brought out, dusted off and presented to the annual Conference of State Secretaries and Journal Editors at Chicago last November as a procedure to get the viewpoint of the medical profession in regard to socialized medicine in general, and the Wagner-Murray-Dingell Bill in particular, before the public. The basis of the contact plan rests upon the firm belief that the well-informed individual doctor can do a better job of discouraging socialized medicine than any other person. Each doctor should be informed, and then he should contact the leaders of his community in business, labor, religion, agriculture, and the professions, and discuss the question.

As an example of the effectiveness of the contact plan, copies of the booklet, "The A.B.C.'s of Social Security," prepared by the Indiana State Chamber of Commerce under the direction of Clarence Jackson, vice-president and general manager, were distributed. Dr. Olin West said that this pamphlet was one of the finest examples of the type of work that can be done when groups other than the medical profession realize that federal control of medicine is a basic, nation-wide battle.

The State Secretaries' Conference approved the "Contact Plan." Indiana representatives were invited to present the plan to the new Council on Medical Service and Public Relations. The plan, along with the "School for Speakers" idea, was approved by the Council, and the following letter was received from the Council:

"I am writing to inform you that I have been instructed by the Council on Medical Service and Public Relations to compliment the Indiana State Medical Association and its officers for the fine piece of work that they have done in behalf of organized medicine. The Council feels that your accomplishments have been outstanding and worthy of signal praise."

12. Contact with men in service. Not the least important job in "public relations" is to be done

with the men in service. Every effort is being made by the Executive Committee and the officers of the state association to make the physicians in service realize that although they are far away from Indiana they are still active members of the Indiana State Medical Association. The monthly "MEDSOC" letters directed to the 1,260 Indiana doctors in service have received universal commendation. These letters are merely a token of expression of the debt owed those who are with the armed forces. It is understood that several other states have instituted a similar series of letters for their men who are in the Army and the Navy.

13. Additional office space. With the institution of regular radio programs and expansion of public relations activities of the state association, additional office space has been obtained for the headquarters office. THE JOURNAL is now housed in separate quarters, at 1017 Hume-Mansur Building, and the space formerly occupied by THE JOURNAL is to be used by the Procurement and Assignment Service. After nine months, authority finally has been received from Washington to employ a full-time person at government expense to handle the Procurement and Assignment Service work. When this full-time employee is received, it is hoped that Miss Reid, whose time has been devoted most largely to the Procurement and Assignment work, will then be able to give her entire time to state medical association matters, after training the new employee in the job.

14. "Radioclast" exposé. Your committee calls attention to the article which appeared in *Radio Craft*, one of the leading radio magazines in the country, in regard to the "Radioclast" exposé which was conducted by the Better Business Bureau. As a result of the investigations of the Better Business Bureau, the pseudo-scientific claims of the "Radioclast" have been blasted and the facts made known to the public not only in Indiana but throughout the country.

B. THE JOURNAL.

The achievements of THE JOURNAL during the past year can best be evaluated by the many letters received from our members, especially those in the armed forces, to whom it seems that it has meant a great deal. They are especially appreciative of the Military News section at this time, for it has often made it possible for them to contact other colleagues when they learned that they were serving in the same areas. Censorship regulations limit the amount of information that can be published concerning members serving outside the United States, but the news items have been as inclusive as possible without giving information that might be of aid to the enemy.

Because of the paper shortage, THE JOURNAL can not exceed the allowance set by the War Production Board, but by holding the press orders to a minimum it was not necessary to reduce the pages during 1943; in fact, the average number of pages per issue slightly exceeded that of any former year. This year's allowance is based on our 1942 paper quota, and the size of THE JOURNAL must be planned accordingly.

Pages printed in 1943 as compared with other years:

Year	Reading Pages	Per Cent Read.	Adv. Pages	Per Cent Adv.	Total	Average Pages Per Issue
1933	634	64	358	36	922	82
1934	604	60	408	40	1012	84
1935	704	62	428	38	1132	94
1936	680	59	472	41	1152	96
1937	674	57	514	43	1188	99
1938	728	59	504	41	1232	102.6
1939	730	59	502	41	1232	102.6
1940	736	59	506	40	1242	103.5
1941	728	58	506	41	1234	102.8
1942	752	60	488	39	1240	103.3
1943	736	58	516	41	1252	104.1

Extra-curricular Service by Doctor Shanklin. During the past year Dr. E. M. Shanklin, editor of THE JOURNAL, has attended the various meetings of the Advisory Committee to the Cooperative Medical Advertising Bureau, and has kept the Executive Committee informed of its activities and the recommendations of its various members. It goes without saying that it is proper that the interests of the state journals should be represented by editors of this group, thus creating greater interest in the state publications.

Cooperative Medical Advertising Bureau. This institution of the American Medical Association is slowly but surely undergoing a thorough remodeling. Established for the benefit of the state journals, there was a feeling that the editors of the state journals should have more "say," and that the state journals should get a better break on advertising. With Dr. Shanklin, together with Dr. Stanley Weld, editor of *The Connecticut State Medical Journal*, and Walter E. Vest, of West Virginia, appointed at the request of a meeting of journal editors and managing editors, the Advisory Committee of the Cooperative Medical Advertising Bureau has been enlarged and should become an active functioning, vital force.

Journal office improvements. The greatest improvement, from a physical standpoint, was the establishment of a new JOURNAL office, consisting of a main office and a small reception room which was converted into a medical library, accommodating the hundreds of books we have received for review in THE JOURNAL, with storage facilities

for our magazines, cuts, and supplies. Most important of all, it affords more room for desks and better organization.

Another worth-while accomplishment during the past year was the conversion of the mailing list into a plate system. With more than twelve hundred members constantly moving around in the armed forces, it had become an endless task to keep their addresses corrected on galley forms, since the names could not be kept in alphabetical order because of mailing regulations, and not only has considerable time and labor been saved as a result of this change, but the actual expense has been reduced over that of the previous year, and it has also been possible to better serve our members. In this connection an alphabetical file was established in THE JOURNAL office, which greatly facilitates matters.

A third achievement was the alphabetization of the Membership Roster, published in the December issue, which because of its volume involved considerable time, but, once established, will be much easier to maintain in the future. That this effort was worth while has been exemplified by the commendation received from many of the physicians' offices, stating that the roster now serves as a source of reference, whereas heretofore they did not know where to look for the names and often had to call headquarters and have them look up names in the *A.M.A. Directory*, et cetera.

Printing costs. During 1943 the printing costs exceeded the budget estimate by \$1,329.84, with further increases for 1944, which gives an idea as to the mounting increase in printing costs, and the problems faced in trying to maintain the standards set for THE JOURNAL. The advertising revenue has increased considerably, but not in proportion, and it has therefore not been possible to balance THE JOURNAL budget on the pre-war allowance for membership subscriptions. However, from the reserve that had accumulated over previous years, it has not thus far been necessary to draw from the association reserve, but THE JOURNAL reserve has now become practically depleted.

Advertising. The first six months of this year show a fair gain in advertising and some new contracts have recently been added, with the promise of some more to come, which we trust will prove more remunerative in the latter half of the year.

A comparison of advertising revenue for the first six months of 1944 with previous years is given:

First Six Months	1941	1942	1943	1944
Bureau agency....	\$2,570.30	\$2,558.89	\$2,950.97	\$3,487.58
Direct	2,400.40	2,554.27	2,347.75	2,507.32
	\$4,970.70	\$5,113.16	\$5,298.72	\$5,994.90

Patronize your JOURNAL advertisers. The members of this association realize, of course, that THE

JOURNAL is sustained largely through receipts from their advertisers. Naturally, our advertisers anticipate an interest in their advertised products; the Executive Committee urges that you supply concrete evidence by answering their ads whenever possible.

C. MEDICAL DEFENSE ACTIVITIES.

1. **Malpractice cases.** A year ago, at the time of this report, August 1, 1943, the following fifteen cases were pending before the committee, two of which were closed during the year, leaving thirteen cases still pending:

- Case No. 200—Suit filed February 12, 1932. Pending.
- Case No. 203—Suit filed August 22, 1934. Defendant deceased, but case still pending.
- Case No. 225—(Closed) Suit filed July 28, 1938. Case dismissed December 13, 1943, for want of prosecution. Expense, \$100, paid February 15, 1944.
- Case No. 226—Suit filed November 5, 1938. Suit withdrawn and another filed January 16, 1939. Pending.
- Case No. 227—(Closed) Suit filed April 7, 1939. Case tried; judgment entered for defendant as result of payment of a settlement. Expense, \$500, paid March 7, 1944.
- Case No. 230—Suit filed November 18, 1939. Pending.
- Case No. 232—Suit filed April 11, 1940. Pending.
- Case No. 239—Suit filed May 1, 1941. Pending.
- Case No. 241—Suit filed February 7, 1941. Pending.
- Case No. 242—Suit filed January 28, 1942. Case venued January 10, 1944. Pending.
- Case No. 243—Suit filed August 15, 1942. Pending.
- Case No. 244—Suit filed March, 1942. Pending.
- Case No. 245—Suit filed January 30, 1942. Pending.
- Case No. 246—Suit filed October, 1942. Pending.
- Case No. 247—Suit filed June 7, 1943. Pending.

Since August 1, 1943, and up to August 1, 1944, the following two new cases have come before the committee, one of which was closed during the year, making a total of fourteen cases pending at the present time as against fifteen unclosed cases at the same time last year:

- Case No. 248—(Closed) Suit filed October 9, 1943. Instructed verdict for defendant May 18, 1944.
- Case No. 249—Suit filed January 6, 1944. Pending.

2. Medical Defense Fund Statement, from August 1, 1943, to August 1, 1944:

Balance, August 1, 1943.....	\$5,803.73
Deposits:	
Dues, 1—1942 member	\$ 75
260—1943 members at 75c.....	195.00
3,195—1944 members at 75c.....	2,396.25
	2,592.00
Interest on bonds.....	365.00
	\$8,760.73

Disbursements:	
Malpractice fees	\$ 600.00
Salary of Association attorney.....	1,800.00
Treasurer's bond	15.00
Printing checks	20.25
	2,435.25
Balance in Medical Defense Fund checking account, August 1, 1944.....	\$6,325.48

III. CONCLUSION.

Your committee is gratified to report that Dr. Charles R. Bird, who has served as chairman of the Procurement and Assignment Service and chairman of the War Participation Committee for five years, is well on the way to recovery after a long and difficult illness. During his absence Dr. John R. Newcomb, editor of the "MEDSOC" letters and "Dr. Goodhealth" on the radio programs, has served as chairman of the Procurement and Assignment Service.

Your committee also wishes to express its hope that Dr. E. O. Asher, who served as a member of the Executive Committee for two and one-half years, will be fully recovered and soon ready for active duty again.

CLEON A. NAFE, M.D., *Chairman*,
C. H. MCCASKEY, M.D.,
J. T. OLIPHANT, M.D.,
N. K. FORSTER, M.D.,
F. T. ROMBERGER, M.D.

COMMITTEE ON PUBLIC POLICY
AND LEGISLATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Public Policy and Legislation makes the following report:

The field of activity of the Committee may be divided into two categories: (1) problems of local and state interest, (2) those of national import.

Local Problems. Throughout the year your Committee has concerned itself largely with candidates for the state legislature. It has made a concerted effort to inform local societies of the importance of acquainting these candidates with the problems of the State Medical Association, pointing out that our problems are not those of selfish interest but based on principles for the ultimate good of the public. These problems have to do with medical care and in the protection of the public health. It is hoped that when the next legislature meets in January, all representatives and senators, state and local officials will have been contacted through

our county medical societies and be thoroughly conversant with the views of organized medicine.

National Interests. Perhaps the most important concern of your Committee is to keep in mind the principal obligation of organized medicine today, namely, **KEEP THE PRACTICE OF MEDICINE ON THE SAME STANDARDS OF HIGH QUALITY AND INDIVIDUAL PRACTICE THAT EXISTED PRIOR TO THE WAR.** This we owe first of all to all of our members in the fighting forces, as well as those at home. The trend to federalization of medical care and public health is increasing. To this end your Committee is making every effort to cooperate with the new council of the American Medical Association and its Washington office. It is obvious now that the technic of federalization is coming through additional legislation whereby federal money is made available for local and state medical care and public health programs. It is also obvious to your Committee that the use of federal money entails federal control. This point can not be over-emphasized. Your Committee therefore urges a strong stand by the House of Delegates, instructing its committees to oppose the acceptance of any federal money for public health and medical care programs in the State of Indiana. Such money is not needed if it is recalled that the State of Indiana has a surplus of over forty million dollars in its treasury, and is thus able to finance any and all medical care and public health programs which are deemed advisable in our own state and local communities.

Your Committee wishes to express its appreciation for the splendid help of all members, recognizing that the real burden of public policy and legislation rests on the shoulders of each county medical society.

NORMAN M. BEATTY, M.D.	} <i>Co-chairmen</i>
J. WILLIAM WRIGHT, M.D.	
GEORGE DANIELS, M.D.	
JOHN HEWITT, M.D.	
J. R. DOTY, M.D.	
M. R. LOHMAN, M.D.	
WALTER F. KELLY, M.D.	

BUREAU OF PUBLICITY

House of Delegates,

Indiana State Medical Association.

Gentlemen:

I. THE BUREAU'S BUSIEST YEAR

It is fortunate that the Indiana State Medical Association had a Bureau of Publicity already established with a background of twenty-two years of solid achievement and experience, for most of the job of public relations demanded by the House of Delegates at its 1943 session fell to the bureau to do. The bureau took on this task with eagerness

and although in some lines, particularly in radio, a good beginning has been made, it realizes only too well that there have been imperfections, faults, and mistakes, and that improvements can be effected if the House of Delegates feels that the venture in the field of public relations is worth while and should be continued.

While 1,260 Indiana doctors are doing everything possible, as members of the armed forces, to defeat Hitler and the Japs, and the rest are doing everything possible to help on the home front, the biggest civilian battle faced by the medical profession during the year was against the Wagner-Murray-Dingell Bill, which would completely socialize American Medicine. Plans for the general offensive against this bill, as outlined by the Executive Committee (acting as the general staff) called for two task forces:

First, the Legislative Committee, whose duty it was to carry the battle to the Indiana Congressmen and state legislators.

Second, the Bureau of Publicity, whose duty it was to carry the battle to the public so that every individual citizen in Indiana would know just what the passage of such legislation would mean.

In order to carry out this large assignment, the bureau used three channels:

1. Public addresses.
2. Newspaper.
3. Radio.

(1) Talking to the Public.

(a) "*School for Speakers.*" Although many trained speakers were available outside the profession to talk about the Wagner-Murray-Dingell Bill, the bureau felt that after all the most effective speaker against the bill would be the average practicing physician, if he could spare the time to prepare himself and talk about the bill to his own civic groups and luncheon clubs.

The bureau asked for a hundred physicians who would be willing to undertake this work. Names of these were supplied by the councilors—several from each district. These men were invited to attend a "School for Speakers" which was held in conjunction with the annual Secretaries' Conference in January.

(b) *Speakers' Kits.* Each speaker was supplied a kit containing copies of what the bureau felt was the best material on the bill. This material came from sources both for and against the measure. The material from the advocates of the bill was thought to be most valuable additions to the kit, as it enabled the speakers to get a line on what the proponents of socialized medicine were saying.

Perhaps the most valuable individual item in the kit was a set of "handy-talky" cards which a speaker could use in preparing his talk—material for a ten-minute or a one-hour discussion. Hints

in regard to making a talk were also included on these cards.

The Council on Medical Service and Public Relations of the American Medical Association asked for fifty of these "Speakers' Kits" and commended them. In addition, many kits were distributed or loaned to individual doctors, members of the Auxiliary, and others who desired to make talks on this subject.

The Michigan State Medical Association adopted the Indiana "School for Speakers" and "Speakers' Kit" ideas.

(c) *Public Meetings.* In addition to some two hundred talks upon the Wagner-Murray-Dingell Bill given by doctors in Indiana, several large, special public meetings were held, either in a public hall or at a joint meeting of the luncheon clubs. Several of these were sponsored by the local Woman's Auxiliary which in each case did an outstanding job. Such meetings were held at Kokomo, Terre Haute, Anderson, Noblesville, Liberty, Columbus, and Greenfield. The principal speakers on most of these occasions were either Clarence A. Jackson, vice-president and general manager of the Indiana State Chamber of Commerce, or Morris Fishbein, editor of *The Journal of the American Medical Association*.

(2) *Newspaper Releases.* The number of newspaper releases during the year was stepped up, and considering the fact that the war made newspaper space rather "tight," the general acceptance of the articles continued to be high.

In regard to the socialization of medicine, the Bureau was careful to stress the fact that the medical profession, while opposed to federal control of medicine and compulsory health insurance, was favorable to voluntary hospital and sickness insurance.

Generally, the editorial policy of papers throughout the state has been critical of federal control of medicine and the regimentation of the profession. Many fine editorials have appeared in the papers pointing out the inherent weaknesses and threat of a system of medical practice that would result if the medical section of the Wagner-Murray-Dingell Bill became law.

(3) *Radio.* A beginning was made in the field of radio, and since January 1, 1944, 201 fifteen-minute broadcasts have been made over five Indiana stations, as follows:

January	13
February	23
March	27
April	28
May	40
June	34
July	23
August	13
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The effort has been a joint one by the Indiana State Medical Association and the Indiana State Board of Health. Mrs. Lotys Benning Stewart, a professional script writer, has prepared the material, and due to the difficulty in getting competent stenographic help she has done the typing and mimeographing and attended to the distribution of the transcripts as well as doing the interviewing, research, and assembling of material necessary to the preparation of the script, and has staged and directed the actual broadcasts themselves. The Bureau hopes that arrangements can be made whereby Mrs. Stewart may be freed from some of these details in order to devote more time to research and the creation of scripts.

The first broadcasts were merely in the form of interviews and discussions on various medical topics—a question-and-answer type of program. This type of presentation has great advantage over a straight fifteen-minute talk where one man merely reads a paper or delivers a lecture on a medical subject. These first broadcasts were given over WISH at Indianapolis.

Starting January 17, 1944, arrangements were made with WFBM of Indianapolis for a series of broadcasts. In this series a second step forward in the technique of broadcasting resulted in an evolution from the medical interview, question-and-answer routine, to the radio "skit" entitled, "Your Health in Wartime."

"Time for another visit with Doctor Goodhealth, your genial guide to keeping well," introduced each program. Most of the scenes of this current series take place in the office of Doctor Goodhealth, where the good doctor discusses health, medicine, life, the war and the world in general. He brings to these discussions a philosophy and scientific knowledge voiced in terms that the average man can understand and, based upon long years of general practice, an intimate acquaintance with medical history, a friendly, human understanding sympathy, and none of this nonsense about federalization or the socialization of medicine.

He talks with his friends, "Bob" and "Tom," and with those who are leaders of Indiana health education and welfare organizations. He discusses the war with medical officers and men in service, some of whom have served at Salerno, on the Anzio beachhead, in England, in France, in Australia, in New Guinea, and at Guadalcanal. These broadcasts by men who have actually been in battle action have been most interesting.

The Bureau of Publicity has been fortunate in having a doctor in active practice who has had broad experience on the professional and civic theater stage to take the leading role of "Dr. Goodhealth." He remains anonymous as far as the radio audience is concerned, but the Bureau feels it is only fair for the members of the profession to know that "Dr. Goodhealth," whose services are gratis, is none other than John Ray Newcomb, M.D. His medical friend is Robert E. Jewett, M.D.,

director of the Bureau of Maternal and Child-Health of the Indiana State Board of Health.

Transcriptions of the "Doctor Goodhealth" series are made and sent to those stations in Indiana who desire them. The societies who desire to broadcast their own program and use their own personnel are sent copies of scripts that may be used as a basis for their own productions.

The utmost cooperation has been received from the local medical societies and from the radio stations throughout Indiana in this experiment in health broadcasting. Of course, there have been limitations; first, due to the fact that for the most part outside of "Doctor Goodhealth" the speakers have had only limited experience. Then, the programs were what is known in radio circles as "sustaining"—that is, the time is given free by the stations, and in most instances they were not on the air during the most advantageous hours. Until these programs are paid for we cannot expect to obtain time when the most people listen to their radios. The third limitation is in regard to subject matter. As these programs are not on a commercial basis, we have had to pull our punches somewhat. We did not dare to go all-out and "blast" the Wagner-Murray-Dingell Bill, for instance. We had to be rather subtle in our approach. We could not "tear" into the cults. We had to stay away from too many controversial subjects. Perhaps that is the best technique anyway. Education rather than propaganda should be the purpose of all programs. The fourth limitation is something which no one can control successfully from a local standpoint; that is, the encouragement of self-medication by the public through the constant ballyhoo of nostrums and patent medicines over the air. It is the duty of the medical profession to warn the public of the dangers and the chance-taking possibilities of self-medication. It is rather incongruous for the public to hear a program that warns against taking a laxative when a person has abdominal pain in one breath and then have the radio urge the complete efficacy of some quick-acting cathartic as the way to better and surer health.

In general, the first concerted attempt with the radio has been satisfactory. Perhaps it is the most extensive job to date by any state society. We believe that greater experience and a removal of some of the limitations here mentioned will enable the Bureau to do the best job done by any state medical organization in radio broadcasting.

II. NEWSPAPER PUBLICITY

The following releases were issued for statewide distribution by the Bureau of Publicity during the year:

Annual Session of the Indiana State Medical Association, at Indianapolis (9 releases).
New Drugs, New Diseases.
Food Fights For Health Too.

Doctors in the War.
Health on Your Christmas Shopping List.
"Take Keer O' Yerself."
Indiana Doctors in 1943.
Tuberculin Testing in Schools.
Meningitis.
Secretaries' Conference (2 releases).
All Heart Trouble Not Caused by Cupid.
Whooping Cough.
Measles.
Industrial Health Conference (4 releases).
National Hospital Day.
Summer Check-ups.
Time to E-Rat-I-Cate.
Doctors of 1776 and Today.
Your Place in the Sun.
Summer-Time Health.

III. MEDICAL MEETINGS

Speaking engagements filled during the year before lay and medical groups follow:

1943

- October 12—Vanderburgh County Medical Society, Evansville.
- October 18—Indiana Pharmaceutical Association, Indianapolis.
- October 18—Woman's Auxiliary to the Madison County Medical Society, Anderson.
- November 4—Woman's Auxiliary to the Indiana State Medical Association, board meeting, Indianapolis.
- December 2—Annual meeting of Indiana Township Trustees, Indianapolis.
- December 8—Thirteenth District Medical Society, South Bend.
- December 17—Cass County Medical Society, Logansport.
- December 17—Indiana Health Council, Indianapolis.
- December 17—Seventh District Medical Society, Martinsville.

1944

- January 4—Annual meeting, Indianapolis Medical Society, Indianapolis.
- January 17—Rotary Club, Columbus.
- January 18—Woman's Auxiliary to the Howard County Medical Society, Kokomo.
- January 21—Cass County Medical Society, Logansport.
- January 30—Secretaries' Conference, Michigan State Medical Society, Detroit, Michigan.
- February 8—The Forty-Niners, Inc., Indianapolis.
- February 18—Hancock County Medical Society, Greenfield.
- February 18—Cass County Medical Society, Logansport.
- February 29—Indianapolis Council on CIO, Indianapolis.

March	14—Kiwanis Club, Greenfield.
March	15—Professional Men's Forum, Indianapolis.
March	23—Vigo County Medical Society, Terre Haute.
March	29—Hamilton County Medical Society, Noblesville.
March	30—Wayne-Union County Medical Society, Richmond.
April	3—Kiwanis Club, Peru.
April	20—Commercial Club, Liberty.
April	21—Postgraduate Ear, Nose and Throat Assembly, Indianapolis.
May	17—Eleventh District Medical Society, Wabash.
May	18—Sixth District Medical Society, Greenfield.
May	24—Ninth District Medical Society, Crawfordsville.
May	24—Fourth District Medical Society, North Vernon.
May	24—Thirteenth District Medical Society, South Bend.
May	29—Eighth District Medical Society and Woman's Auxiliary to the Madison County Medical Society, Anderson.

This list, of course, does not include the many talks, many of them as a result of the "School for Speakers" suggestions, delivered by physicians throughout the year to public and medical groups without arrangements being made through the Bureau.

IV. OTHER DUTIES OF THE BUREAU

One of the principal and most pleasing duties of the Bureau of Publicity has been to serve as the advisory committee to the Woman's Auxiliary. In addition to sponsoring several public meetings to combat socialized medicine, which have been urged by Dr. Morris Fishbein as a type of endeavor that can serve as a guide for other state and local auxiliaries, the Indiana Auxiliary has outlined a program of Auxiliary functions which will be presented at the annual Auxiliary meeting in October.

Under the direction of the War History Commission, foundations are being made for the medical history of the war. This phase is being directed by the Bureau of Publicity. A complete outline of work will be presented to the Commission within a short period of time. It calls for active participation by a physician assigned to do the job as World War II historian in each county medical society, and it is a task for the present Committee on Medical History.

V. FINANCIAL STATEMENT OF THE BUREAU

The expenditures of the Bureau from August 1, 1943, to August 1, 1944, follows:

Clippings	\$ 59.78
Postage	135.19
Stationery and mimeograph supplies	165.12
Printing	78.45
Salary, script writer	906.69
Broadcasting expense	182.94
Miscellaneous	59.66
Total expense	\$1,587.83

H. G. HAMER, M.D., *Chairman*,
BEN B. MOORE, M.D.,
K. R. RUDELL, M.D.

COMMITTEE ON CIVIC AND INDUSTRIAL RELATIONS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Civic and Industrial Relations had no activities during the year and therefore has no report to submit.

FRED B. WISHARD, M.D., *Chairman*,
M. C. TOPPING, M.D.,
G. H. WISENER, M.D.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Because of the war conditions, this committee has not functioned. It was thought best by several members of the committee not to make any effort at graduate work in the state other than that which was being promoted by the university and the Committee on War-time Graduate Medical Meetings.

The chairman of your committee did attend the meeting in Chicago, during the past winter, of the Committee on Medical Education and Hospitals of the American Medical Association.

HERMAN M. BAKER, M.D., *Chairman*,
M. S. DAVIS, M.D.,
ROBERT M. MOORE, M.D.,
E. N. KIME, M.D.,
C. J. CLARK, M.D.,
O. O. ALEXANDER, M.D.

THE JOURNAL

House of Delegates,

Indiana State Medical Association.

Gentlemen:

Since our last report to your body, *THE JOURNAL* has, we believe, made much progress. The matter of pages published, together with the advertising picture, is well covered by the Managing Editor, Thomas A. Hendricks, and is carried as a part of the report of the Executive Committee, to which report you are referred.

Wartime publications of all sorts have had their troubles, what with ever-increasing costs and the sometimes almost interminable delays in getting this and that done, but *THE JOURNAL* seldom has been more than a day or two late in appearing on your desks, and when it finally appears there we feel that few medical magazines are to be compared with it—all of which means that the entire staff is mighty proud of our production.

We take this opportunity to compliment our printer. We have talked with representatives of some of the largest printing concerns in the Middle West, all of whom tell us we are getting a good job; that our magazine, mechanically speaking, is one of the best. Yes, we often have delays in the shop, but what shop does not have delays, with the current work to be carried on and at the same time each of the personnel doing his war bit? So, we take this occasion to pat our printer on the back.

Probably the outstanding success during the past twelve months was our "War Number." It went over big, not only among the home folks but over the entire country as well. This was a prodigious undertaking, for this is a big war, covering a lot of territory. We feel that our story was well told, with the assistance of Army, Navy, Marine, and Air Corps men. We believe that the time and money spent in the production of this number was much worth while.

THE JOURNAL has carefully followed our special committee meetings, such as the Industrial Health Committee which held an extended session in Indianapolis in April. The meeting was covered each day, and a full report of the proceedings was published in *THE JOURNAL*.

The financial picture shows that the magazine is being published at an increased cost over former years; this, of course, is unavoidable. We have held down these costs in so far as possible, but there still is that increase. There has been an increase in printing cost for the first six months of this year, as compared to the same period last year, that amounts to well over five hundred dollars.

The plate system for our mailing list has worked out very well, exceeding our wildest expectations. It is a time-saver as well as a money-saver. Another job the staff has done was to compile an alphabetical roster of our entire membership. Heretofore it has taken a lot of time to look up the name and

location of a physician listed in our Membership Roster.

And are we proud of our headquarters' staff! Miss Rokke and her capable assistant, Miss Stanley, are doing a "swell" job of it — to borrow one of the pet adjectives of "TAH." And we like to think that the change in quarters has had a very happy effect on these two folk. Formerly they were cooped up in a "2 x 4" space back in a corner of the headquarters' office, where space was at a decided premium and the coming of a visitor was a calamity. It meant that someone had to give up his place to accommodate that visitor. Now the picture is different; we have an office of our own, not too large, but one in which we can get around, accommodate visitors, file material without having to discard something else, and we finally have our ever-growing library so disposed that reference books are readily accessible.

As we have said in previous years, *THE JOURNAL* comes to you every month, so you have a monthly report of the doings of those responsible for its publication. Scientifically, it is comparable to any publication of a like nature in the country. That our magazine is fully appreciated by the members in service is attested by the large numbers of letters that come from these men each month. They especially like the pages concerning the doings of men now in service and, in passing, we well may compliment Miss Rokke for her work in locating and compiling that information — in itself one big job.

Thus, we have been busy; we have endeavored to give a complete cross section of what is going on in Hoosier Medicine, for this is a Hoosier magazine—a lot of outsiders read it, too, but primarily it is a Hoosier institution. We are all proud of being able to play some part in its production.

The paper problem, acute with many other state medical journals, has been handled exceedingly well, we believe, by those of the staff responsible for that part of the program. It is quite possible, however, that in the coming year more retrenchment in this regard will have to be made. At this writing the paper shortage, covering all sorts of paper, is indeed acute, but with the ending of the war in the European area, apparently in the near future, it may be that this shortage will disappear before another year has ended.

In conclusion, we wish to thank the members of the association for their assistance in this project, and we have had practically unanimous support from the membership. It has, indeed, been a pleasure for all of us to have served you another year.

E. M. SHANKLIN, M.D., *Editor.*

*Be seein' you
at the state meeting!*

COMMITTEE ON SECRETARIES' CONFERENCE

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The Secretaries' Conference was held Sunday, January 23, 1944, at the Indianapolis Athletic Club. At this time a School for Speakers was established at the morning session, with Floyd T. Romberger, M.D., acting as chairman. Other speakers for the morning session were Homer G. Hamer, M.D., chairman, Bureau of Publicity; Clarence Jackson, vice-president and general manager, Indiana State Chamber of Commerce; W. Norwood Brigance, Ph.D., professor of speech, Wabash College; and F. S. "Davy" Crockett, M.D., Lafayette.

The afternoon session was called to order by the chairman, and the secretaries were welcomed by N. K. Forster, M.D., president-elect of the Indiana State Medical Association. Charles N. Combs, M.D., spoke on "Hospital Plans in Indiana." Blue Cross and medical service plans were discussed by L. Fernald Foster, M.D., secretary, and William J. Burns, executive secretary, of the Michigan State Medical Society. J. W. Holloway, Jr., director of the Bureau of Legal Medicine and Legislation of the American Medical Association, talked on "National Legislation," and Norman M. Beatty, M.D., and J. William Wright, M.D., Indianapolis, discussed "Local Legislative Problems." E. M. Shanklin, M.D., editor of *THE JOURNAL*, discussed participation in making a better *JOURNAL*.

J. T. Oliphant, M.D., president of the Indiana State Medical Association, presided at the dinner meeting. E. J. McCormick, M.D., member of council on Medical Service and Public Relations of the American Medical Association, discussed "Public Relations and the Medical Profession." The meeting was very successful and the attendance was one of the best.

A. M. MITCHELL, M.D., *Chairman,*
W. M. DUGAN, M.D.,
W. G. PIPPENGER, M.D.,
O. E. WILSON, M.D.,
O. A. TURNER, M.D.

PERMANENT STUDY COMMITTEE ON HEALTH INSURANCE

House of Delegates,

Indiana State Medical Association.

Gentlemen:

Your Committee was appointed by the House of Delegates at the 1943 annual session to recommend "the most feasible" insurance plan for medical service.

Over the past several years a tremendous amount of study and effort has been devoted to attempts to develop methods of distribution of medical care and alleviation of the high costs of illnesses, particularly for those with small incomes, which are unpredictable as to amount and time of occurrence.

Your Committee has met numerous times and has investigated the development of plans and methods of the distribution of medical care in other states and countries, and has arrived at the conclusion that the best present solution is the adoption of a state-medical-association-sponsored plan for prepayment for medical service—that is, the adoption of the insurance principle to payment for medical service.

In Indiana, due to deficiencies for this purpose in the nonprofit corporation statutes and due to the lack of specialized legislation permitting the formation of a voluntary prepayment medical service plan, it will undoubtedly be necessary to organize under the insurance statutes of the state either a mutual or stock insurance company or association in order to carry out the recommended proposed program.

Because the required capitalization or funds necessary to qualify for transaction of business are much more probable of attainment, your committee recommends that a mutual insurance company be organized with contributed funds of \$25,000.00 and an additional \$25,000.00 to be derived from advanced premiums, a total of \$50,000.00, the amount necessary to meet the qualification requirements of the statute.

Contributions to the funds of the insurance company can be made on a so-called "surplus contribution note," repayable out of surplus earnings as, if, and when such funds are available.

The plan proposed by your committee would provide:

- (1) For all professional medical, surgical and obstetrical services while the patient occupies a ward or semi-private hospital bed, including anesthesia, x-ray, laboratory and electrocardiographic services.
- (2) Emergency surgical services in connection with non-hospitalized injuries for the first twenty-four hours.

These services will be subjected to the following limitations:

- (1) Ten-month waiting period for obstetrical cases.
- (2) No obstetrical benefits unless family is enrolled.
- (3) X-ray service limited to fifteen dollars in any one year.
- (4) Twenty-one days of medical care in any one year.

Your Committee contemplated that members of the profession enter into agreements with the

service to provide contract benefits at fees in accordance with necessary rules and regulations determined by a committee or committees to be appointed by the Association for that purpose.

It is further contemplated that physicians so agreeing will abide by fees established by these committees except when an unmarried subscriber's annual income exceeds \$2,000.00, or a married subscriber's total family annual income exceeds \$2,500.00.

The subscriber rates proposed for this coverage are approximately 95c per month for an individual contract, and \$3.25 per month for the family contract.

Necessary action to incorporate such a company should be referred to a committee of the state association to draw up incorporation papers—Articles and By-Laws which should designate the desired number of Directors, which is suggested at from eleven to twenty-five. By-Laws should outline the various operating committees to transact detailed business of the organization, such as: Executive Committee to conduct the affairs of the organization between meetings of the Board of Directors; Medical Committee to determine and resolve matters in relation to the practice of medicine, fees to be paid in connection with services rendered by participating physicians; and Finance Committee to determine and resolve questions in connection with the company's financial structure and investments, et cetera. By-Laws should also designate the offices and duties of the offices of the corporation and qualifications of those to hold office, such as president, vice-president (one or more), secretary, treasurer, and so forth. By-Laws should further designate the method of employing the active manager of the organization and his qualifications.

A preliminary draft of a proposed subscriber's agreement which sets forth the benefits offered, limitations, procedure for enrollment of subscribers, and rights and privileges under the contract has been prepared by the committee. The subscriber rates proposed will be available for any action committee.

It will be noted that provisions of the Medical Plan Contract in regard to enrollment requirements, transfer privileges, et cetera, in connection with the subscriber's rights and privileges, are, insofar as practical, identical with those set forth in the proposed contract of the Mutual Hospital Insurance, Inc., (Blue Cross Hospital Service of Indiana) plan; it being contemplated that upon the incorporation of the medical plan arrangements will be made with the hospital insurance company for a joint enrollment and subscriber relations administration for the benefit of reduced operating costs and economies.

Your committee believes that the proposed plan meets in all respects the principles laid down by the American Medical Association in regard to sound medical service plans.

Your committee recommends that a special reference committee of the House of Delegates be appointed to consider this report and other reports, and resolutions having to do with the prepayment medical and hospital care plans and programs.

The committee cannot express sufficient thanks and appreciation to Jay C. Ketchum, executive vice-president of the Michigan Medical Service and president of the Medical Service Plans Council of North America, for the inestimable services rendered the committee in preparing this report and aiding in the study of prepayment plans.

W. H. HOWARD, M.D., *Chairman*,
W. U. KENNEDY, M.D.,
LYNN W. ELSTON, M.D.,
A. C. YODER, M.D.,
CLAY BALL, M.D.,
A. P. HAUSS, M.D.,
C. P. FOX, M.D.

COMMITTEE ON NECROLOGY AND HISTORY

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The report on necrology is published annually in the earliest possible number of THE JOURNAL. The committee finds it difficult at the present time to make much headway in the matter of a State Medical History. It has therefore been decided to try to accomplish as much as possible in the matter of securing source material. To that end a number of men have been asked to prepare adequate histories of their own or adjoining counties. It is hoped that by this method we may collect considerable material which eventually may be worked into a complete state history before the centennial in 1949.

JAMES B. MAPLE, M.D., *Chairman*,
W. D. INLOW, M.D.,
C. N. COMBS, M.D.,
EDGAR F. KISER, M.D.,
L. G. ZERFAS, M.D.,
G. T. WILLIAMS, M.D.

COMMITTEE ON STUDY OF HIGH SCHOOL ATHLETICS

House of Delegates,

Indiana State Medical Association:

Gentlemen:

The Committee on Study of High School Athletics of the Indiana State Medical Association from its

first meeting in 1928 until the present time has worked with the following thoughts in mind:

1. Physical fitness for all those who participate in athletics.
2. Cooperation with the controlling authorities of the Indiana High School Athletic Association in their effort to avoid abuses.
3. Encouragement of competition because of its powerful incentive for self-improvement.

For those who are physically unable to enjoy the benefits of competition there have been in most communities many facilities for physical betterment. The contention that the competitive system helps only a few is entirely fallacious. For every boy on a playing squad there are dozens of boys trying to improve enough to get a place on that squad. This is not to say that many boys will not be physically benefited by special measures. These measures should be developed more fully, and participants should be encouraged to take advantage of them.

It is a serious question whether or not the boys of junior high school age should not be included under the control of some governing body. At the present time youngsters in the sixth, seventh, and eighth grades have very little guidance and practically no control over their physical activity, although conditions vary greatly in different cities of this state in this respect.

It has been proved beyond all doubt that hard competition develops resourcefulness and initiative, which is just as important as physical development.

W. D. LITTLE, M.D., *Chairman*,
 GEORGE S. BOND, M.D.,
 H. C. WADSWORTH, M.D.,
 G. A. THOMAS, M.D.,
 WILL C. MOORE, M.D.,
 WILL A. THOMPSON, M.D.,
 J. E. McMEEL, M.D.

COMMITTEE ON MENTAL HEALTH

House of Delegates,

Indiana State Medical Association.

Gentlemen:

It seems that your Committee on Mental Health is an inactive, useless organization, as no formal meetings have been held in the past year, primarily because no specific problems have been brought to its attention, and secondarily, because of transportation difficulties and overwork of its members.

Your attention is invited to this committee's report of last year. It may be said that there is no change, certainly no improvement in the neuro-

psychiatric situation in Indiana as outlined at that time, nor is there any hope for an improvement during the war period.

Our concern now is largely with post-war activities. We are all aware of the fact that there has been a sharp increase in neuropsychiatric problems in the past three years, and there is every reason to believe that with cessation of hostilities this increase will continue, not only among those discharged from the military service but civilians as well. The great majority of these service men and women will be cared for by the Federal Government, which will require a large number of specially-trained doctors and nurses. A great many young medical officers of the Army and Navy are being given intensive training in neuropsychiatry. A certain number of these men will choose this as a specialty; many, no doubt, will remain in the government service, others will return to civil life to practice their specialty. We believe these young men, after return to private practice, should be encouraged to further their training and establish themselves in this specialty, which, of course, will relieve the load now carried by the neuropsychiatric group in civil practice.

The same thing may be said of nurses, technicians, and social workers who have had special training during their military service, for they will be in great demand after their return to civil life.

As stated in our report of last year, hospital facilities are painfully inadequate. Plans should be made to expand state, county and municipal institutions, not only to carry the psychiatric overload at this time but to anticipate the later increased demand.

Under present conditions we believe the various public and private neuropsychiatric hospitals are doing everything possible in the care of the mentally ill, although not with the thoroughness and dispatch which we would desire.

Again, we express our congratulations to members of this group who are now in the military service. Reports of their excellent service are continually coming to our attention.

LARUE D. CARTER, M.D., *Chairman*,
 L. P. HARSHMAN, M.D.,
 J. H. HARE, M.D.,
 MAX BAHR, M.D.,
 C. L. WILLIAMS, M.D.,
 W. C. VAN NUYS, M.D.

Better take a few days off
 to relax—October 3, 4, and 5—
 and attend your state meeting

**ADVISORY COMMITTEE TO THE BUREAU
OF MATERNAL AND CHILD-HEALTH
OF THE INDIANA STATE BOARD
OF HEALTH**

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

A joint meeting of the members of the Indiana State Board of Health and the Advisory Committee was held May 28, 1944.

Present at the meeting: H. M. Baker, M.D., president of the Board; Ernest Rupel, M.D., board member; E. M. Van Buskirk, M.D., board member; T. B. Rice, M.D., secretary of the Board; R. E. Jewett, M.D., director of the Division of Maternal and Child-Health. Representatives of the Advisory Committee present: H. F. Nolting, M.D.; F. J. Hudson, M.D.; J. C. Carter, M.D.; and J. D. Van Nuys, M.D.

**I. REPORT OF MATERNAL AND CHILD-HEALTH SERVICES
AND THE EMIC PROGRAM**

Dr. Jewett reported the status of the services of the Division of Maternal and Child-Health, explaining that the administrative load of the EMIC program had caused curtailment of certain phases of the services, necessitating the transfer of Nutrition to the supervision of the Division of Health and Physical Education, although the administration and program remains a cooperative one with the Division of Maternal and Child-Health. Also, that the Dental Services were to be carried out in the future in cooperation with the Indiana University School of Dentistry. He pointed out that other services were being carried as well as could be with the shortage of personnel—that many of the nursing services had been curtailed because of the loss of nurses to the armed forces. The Maternity Delivery Services, in particular, have suffered. The Allen County Maternity Nursing Service is being discontinued, and those in several other areas also have been discontinued because of the shortage of personnel.

The statistical report of the Maternal and Child-Health EMIC Program was made, and is as follows:

Report of Obstetric and Pediatric Cases Authorized, Cases Completed, and Cost of Cases Completed under the EMIC Program in Indiana, through April 30, 1944—

	Maternity Cases	Pediatric Cases	Total
Number of cases authorized	10,393	1,421	11,814
Number of cases completed and closed out.....	4,546	683	5,229
Cost of care for cases closed out	\$418,836.38	\$24,712.92	\$443,549.30
Average cost of care for cases closed out.....	92.13	36.18	
Combined average for both Maternity and Pediatric Cases			84.82

The status of the Appropriation Acts for the EMIC Program was reported, the deficiency ap-

propriation of \$6,000,000 for the remainder of the fiscal year having been passed, and the \$40,000,000 Appropriation Act for the fiscal year 1945 is pending. This Act again contains the proviso permitting authorization for care of the families of men of the third, second, and first salary grades when the need for care is indicated. (Note: The Appropriation Bill has since been passed without any provision for the families of the men of the first, second and third salary grades.)

Dr. Nolting raised the question regarding delay in making payment for services of physicians after report has been filed. Dr. Jewett explained that this was in about fifty per cent of the cases due to the failure of the doctor to make his report, or to make it in such a manner that further clarifying correspondence becomes necessary in order to pass the voucher for payment. It was also explained that delay is due to the tremendous load of correspondence and due to the fact that personnel is hardly adequate to keep up with the load. It was also explained that the necessity of filing the official state voucher, No. 137, and its passage through the State Board of Accounts and State Treasurer also entails some delay. Therefore, after filing a report it requires anywhere from two to six weeks before final payment is received by the physicians. This may occur even in an uncomplicated case.

The question was brought up regarding the attitude and cooperativeness of the hospitals of the state, nurses, and physicians toward the EMIC Program. It was reported that the Indiana State Hospital Association and the hospitals of the state were cooperating splendidly. The State Nurses' Association has appointed a committee which assisted in developing policies and fees for nursing care, and private nursing agencies in the cities have all established working agreements with the Indiana State Board of Health. The medical profession has, with minor exceptions, shown an excellent spirit of understanding and cooperated in the program in spite of the burden of the work and added responsibilities thrust upon them. The minor exceptions have been due mostly to misunderstanding of the policies and procedures involved under the program.

II. MEDICAL, NURSING AND HOSPITAL SERVICES

A. Hospital Care.

Dr. Jewett explained the methods of arranging to pay for hospital care at an all-inclusive per patient day rate based upon the in-patient operating costs of the hospital. It was also explained that the hospital of twenty-five beds or less could now be paid at a rate of \$5.77 per day, which is the average minimum rate established by hospitals submitting operating statements.

Dr. Van Nuys pointed out that a cost rate worked a hardship in some small hospitals where hospital care could not be extended more than two or three days, since maternity service care is higher than

other services, and since the first day or two of care, which includes surgery, etc., is costly. No solution to this problem is evident, however, at this time.

B. Nursing Care.

It was explained that we did provide for special duty nursing care at the time of delivery, or for the acutely ill, at local prevailing rates, or at \$6.00 per eight-hour day and 75c per hour for overtime.

C. Ambulance Service.

Methods of payment for ambulance service were reported, stating that for the state as a whole the rate of payment is \$1.50 loading charge and 30c per loaded mile with a minimum of \$3.00 for five miles or less. In the city of Indianapolis the method of payment is a flat rate of \$5.00 for ten miles or less, and 30c per mile for additional mileage.

D. Dr. Jewett explained the methods of application, making authorization, and reporting of services.

Dr. Jewett pointed out that the question of osteopaths participating had been raised by various men in the profession. It was explained that under a proviso attached to the Appropriation Act of June, 1943, osteopaths may participate in the program when rendering obstetric care. However, this proviso is specific, and the United States Children's Bureau still maintains standards limiting other types of service, such as pediatric care of infants, to physicians who have graduated from medical schools approved by the Council on Medical Education of the American Medical Association.

The question of physicians making charges in addition to that authorized by the Indiana State Board of Health was brought up for discussion. All the correspondence, directives and regulations from the United States Children's Bureau in regard to this subject were discussed. It was decided definitely that the intent of the Act was perfectly clear, that all care authorized and rendered on and after the effective date of authorization should be without any charge to the patient or family upon penalty of cancellation of all authorizations. In regard to violation of this legal intent of the Act, it was the decision of the group that any other action or agreement between patient and physician was averse to the legal intent of the Act, but that since we do not act as a police body, violation remained entirely a question of patient-physician relationship, and rested upon the conscience of the parties involved. It was agreed, however, that both parties should be fully informed of the strict legal limitations, and that any act in violation was in direct antipathy to the legal interpretation of the Act governing the administration of this program.

It was the consensus of opinion that specialists who ordinarily charged higher fees than the flat minimum fee allowed should either accept these

cases without question and the fees payable by the State Board of Health without additional cost to the patient or family, or that they should refuse to accept cases and refer them to general practitioners. A third alternative was mentioned—that the person ordinarily eligible could assume the responsibility for payment of care as a private patient, and not make application for assistance to the Indiana State Board of Health.

III. BROWN COUNTY MATERNITY NURSING SERVICE

Dr. Jewett explained the proposed establishment of a maternity nursing service in Brown County, this to be done through the cooperation of the Indiana State Medical Association, The Brown County Health Council, and local participating physicians. The proposal entails a maternity clinic service, conducted by local physicians, for expectant mothers unable to engage the services of a personal physician for financial or other reasons. Service will be provided also for a nurse with special maternity training to assist local physicians providing maternity care in the home, and to attend such cases referred by the clinic physicians in emergency, when hospital care is not indicated or not available, and when a physician is not available for delivery in the home.

The Advisory Committee jointly with the State Board members approved of this program, and referred the matter to the Executive Committee of the Indiana State Medical Association for final approval.

IV. REVISION OF EMIC PLAN AND FEE SCHEDULE

The committee reviewed EMIC Information Circular No. 1 of the United States Children's Bureau, which outlines new policies, extension of present fees, and establishment of new fees for the services of practicing physicians. It was also agreed that a new plan should be submitted by the Division of Maternal and Child-Health to the Children's Bureau, adopting this circular as the basis for policies and fees for the EMIC services. It was agreed that upon receiving approval of this revised and extended plan from the United States Children's Bureau the entire revised plan and fee schedule would be printed or mimeographed and sent to each practicing physician.

V. BETTER STATE REPRESENTATION AT PLANNING CONFERENCES OF UNITED STATES CHILDREN'S BUREAU

It was reported to the meeting that the MCH directors and State Health officers of the north central states propose to make a plea for better representation of the state agencies at planning conferences of the United States Children's Bureau affecting the EMIC Program.

A letter drafted by Dr. Jewett, to be adopted and submitted over the signature of the Commissioners of Health of the forty-eight states, was read. By agreement approval was given for the

State Health Commissioners to submit this letter to the Association of the State and Territorial Health Officers, who, in turn and as individuals, submit the proposals to the United States Children's Bureau.

The over-all response by Indiana physicians giving their services, under the provisions of the MCH program, to servicemen's wives and children has been quite satisfactory.

H. F. NOLTING, M.D., *Chairman*
J. C. CARTER, M.D.
FOSTER J. HUDSON, M.D.
JOHN D. VAN NUYS, M.D.

LIAISON COMMITTEE OF THE DIVISION OF SERVICES FOR CRIPPLED CHILDREN

House of Delegates,

Indiana State Medical Association.

Gentlemen:

No meeting of this committee was held, and no notification of any changes in the program has been received.

I. C. BARCLAY, M.D., *Chairman*,
J. H. WEINSTEIN, M.D.,
JOHN H. GREEN, M.D.,
GEORGE COOK, M.D.,
L. A. ENSMINGER, M.D.,
R. L. SENSENICH, M.D.,
G. H. KAMMAN, M.D.

AUDITING COMMITTEE

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The Auditing Committee met at the Indiana National Bank on July 20, 1944, and examined the securities of the Association.

Three of the \$1,000 United States Treasury Bonds in the Medical Defense Fund were called in April, 1944, and this amount was re-invested in Series G War Bonds. With the exception of this change, the investments held by the Association are listed by George S. Olive and Company, certified public accountants, in their annual report for the year ending December 31, 1943, and this report is carried in the treasurer's annual report (see page 482). All of these securities were found to be in order in both the general fund and the medical defense fund.

Cash balances in The Indiana National Bank, The American National Bank, The Fletcher Trust

Company, and The Bankers Trust Company, as shown by the bank statements, also were examined. These accounts consist of the general headquarters' office fund, the medical defense fund, THE JOURNAL fund, and the petty cash fund, respectively.

O. B. NORMAN, M.D., *Chairman*,
C. C. BITLER, M.D.,
HARRY L. FOREMAN, M.D.

COMMITTEE ON CONTROL OF CANCER

House of Delegates,

Indiana State Medical Association.

Gentlemen:

Your committee reports that this year has been one of activity and accomplishment in the work on the prevention and cure of cancer in Indiana.

We have, of course, worked in conjunction with the Women's Field Army throughout the year. As this field army grows in experience, it becomes a more useful instrument in this work year by year, and the fact that Indiana is now definitely cancer-conscious is due in large measure to the effect of those women who have given so freely and willingly of their time and energy to advance the dissemination of cancer knowledge among the public in our state.

The appointment of Mrs. Ronald M. Hazen to the position of commander of the Indiana Division of the Women's Field Army has proved a great step in the right direction. Under her guidance much lost motion and needless expense has been eliminated. An improved organization has been accomplished, and we are now in position to go forward with real incentive and to expect results with which we can be truly satisfied. It is with pleasure that your committee reports that Mrs. Hazen has been reappointed by the headquarters office in New York for another year.

We also wish to report that a much better feeling exists in the profession for the work these women are doing, and there is a real willingness on the part of the physicians to cooperate. By the advice of these physicians many missteps have, no doubt, been avoided. This is the spirit in which all diseases are eventually conquered. While we all realize that this is an enormous undertaking with plenty of discouraging features, nevertheless we believe that Indiana is more than holding her place among states in this work, as evidenced by the following report of our year's activities.

The following executive advisory board of physicians was appointed by the Women's Field Army: C. A. Stayton, D. D. Bowers, Clyde Culbertson, Charles W. Myers, John Day, and Thurman B. Rice—all of Indianapolis. From this committee certain men were chosen to carry out projects of

the Women's Field Army. To Doctor Stayton was assigned the establishment of diagnostic clinics; to Doctor Culbertson, professional education; and to Doctor Rice, public education.

Throughout the state fifty-two counties are fully organized as against twelve counties in 1943.

Money was collected from counties as follows:

1940	-----	\$ 9,530.
1943	-----	12,430.
1944	-----	22,951.

In 1940 five counties were over their quota, while in 1944 twenty counties were over their quota and had money returned to them for local use.

Projects such as diagnostic clinics have been started in counties during 1944.

One hundred twenty-five thousand pieces of literature on cancer control were distributed in the state during 1944.

Five counties went over their quota in the 1944 campaign.

At a meeting of the directors and the executive committee on June 28, the following resolutions were passed and have been approved by the national organization:

"Resolved—That the Board of Directors of the Women's Field Army assume financial responsibility for a fellowship at the Indiana University Medical School, Robert Long Hospital, over a three-year period for the training of a pathologist to serve in specialized diagnosis and research in the field of cancer.

"That \$2800.00 be set aside from this year's surplus fund to assure costs of such fellowship at the rate of \$1400.00 per year for two years, and the third year to be an obligation upon the board either for later appropriation or to be otherwise handled as a special project. That selection of candidate be left to the head of the medical school and permanence of trainee be assured the directors in advance of financing arrangements.

"Resolved—That the Board of Directors of the Women's Field Army sponsor services on the part of Miss Millicent Duckworth, trained medical worker, in the follow-up of cancer clinic cases in the Indiana University Medical Center Clinic and the Patrick Clinic at the City Hospital of Indianapolis; salary of \$1800.00 per year to be financed, \$1000.00 out of the reserve of the Marion County division and \$800.00 to be paid by the Indiana Division of the Women's Field Army."

Mrs. Hazen attended a regional meeting for Regions 1, 2, and 3, in New York, in May. Mr. Neff, Mr. Ripley, Dr. Adair, Dr. Little and other leaders in our work took part in the program.

Probably the highlight of the year was the meeting of the Annual Institute held at the Claypool Hotel, Indianapolis, February 22, 1944. The counties of the state were well represented at this

meeting, which showed a registered attendance of 150. Many physicians attended this meeting. The principal address was delivered by Dr. Arthur Curtis, from the Department of Gynecology, Northwestern University, Chicago.

Our appreciation is gratefully extended to the Women's Field Army, Indiana State Board of Health, Indianapolis City Board of Health, Indiana University, and all other organizations in the state which have contributed to our work during this year.

E. E. PADGETT, M.D., *Chairman*,
C. A. STAYTON, M.D.,
H. C. METCALF, M.D.,
J. R. BLOOMER, M.D.,
J. R. YUNG, M.D.,
JOHN R. PEARSON, M.D.

COMMITTEE ON VENEREAL DISEASE

House of Delegates.

Indiana State Medical Association.

Gentlemen:

Your Committee on Venereal Disease has had no meeting during the year as no special questions arose nor were there any suggestions as to alterations of plans being carried on. However, one question, not in the direct province of our committee, occurs to us to which we wish again to call to the attention of the House of Delegates of the Indiana State Medical Association.

The Federal Government is making greater and greater efforts in its encroachment on matters of State Rights, and not the least of these efforts is its attempt at further inroads on private practice and individual state-controlled public health.

So well known are the main facts (the latest being that the Surgeon General of the Navy is asking for completely-controlled general clinics under Federal Public Health Service) that your committee does not wish to consume the time to enumerate them in its report, but wishes again to draw the attention of the Executive Board of the House of Delegates to the subject, and to enter its protest against further and unfair encroachment by the Federal Government into the State Rights control of public health and the private practice of medicine.

ERNEST O. NAY, M.D., *Chairman*,
ROBERT G. MOORE, M.D.,
F. R. N. CARTER, M.D.,
B. W. RHAMY, M.D.,
W. P. MORTON, M.D.,
L. E. DUPES, M.D.,
LOWELL GREEN, M.D.,
WM. R. TAYLOR, M.D.,
MINOR MILLER, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

First, we wish to express our appreciation for the opportunity given us to serve on this committee. It has been a pleasure and a privilege to work upon these problems having to do with the important subject of industrial health, and whatever has been accomplished is due to cooperative effort.

The committee is composed of one member from each district. The purpose is to have each member act as ambassador to his district, with the hope that at least once a year each society will have a meeting devoted to industrial medicine and health. Each should know better than anyone else the type of program best suited for his locality.

Three districts have held a meeting devoted to industrial health with profitable results. It is our hope and recommendation that each district will do likewise within the year.

The Tenth District Medical Society had an evening meeting on rehabilitation. This was in the form of a panel discussion. Four speakers talked for fifteen minutes each—first, on rehabilitation of the tuberculosis patient in industry; second, the rehabilitation of fractures and loss of limb; third, rehabilitation of the cardiacs, and fourth, what to do with the neuropsychiatric in industry, particularly thinking of the postwar problems. The heads of all industries were invited as guests of the society. There were about forty-five industries represented, and about one hundred and fifty in attendance. The discussions were most interesting and informative. The industrialists entered readily into the discussions. A surprising amount of information was gleaned from them. The good will derived was important.

A meeting was held in Indianapolis to which was invited the Industrial Board of the State of Indiana; state representatives of the A.F. of L. and C.I.O.; several representatives of industry; the secretary of the Indiana Manufacturers' Association; the secretary of the Indiana State Chamber of Commerce; Representative and co-author of House Bill No. 11, Mr. J. Otto Lee; your attorney, Albert Stump, and others.

The purpose of the meeting was to discuss the administration of House Bill No. 11. This, as you know, is a bill making it possible by amending our present state industrial Act to waive a physical handicap. When this bill is fully understood and becomes entirely workable, we believe this will have been the most humane and important piece of legislation for many years. The meeting was historically unique in the harmonious discussion by such a mixed group. We hope and believe some good was obtained. At least management, labor, medicine and allied interests were all present at the same time and were free in their discussion.

The Industrial Postgraduate Meeting in Indianapolis, April 19 and 20.

Some time ago your committee appreciated the fact that organized medicine had a stake in rehabilitating and finding employment for the physically-handicapped veteran. In order to clarify medicine's position in this field, the employability of the handicapped veteran was made the keynote of the program. This type of program was the first of its kind on a state level and was later followed by similar programs in other states.

Never has there been a better array of speakers on any program of industrial medicine in the United States. Each was an authority and master in his field, and internationally known for his work.

Your committee was sorely disappointed by the poor attendance. We have never been to a meeting where so much valuable information was disseminated in two days. Yet there were only two hundred fifteen registered, and approximately fifty of them were representatives of industry. The discussions by the industrialists of the various papers were excellent.

Particular credit for the type of program goes to your most efficient and genial secretary, and to Dr. Louis W. Spolyar, director of the Bureau of Industrial Hygiene, Indiana State Board of Health. It was through his good office that the speakers were obtained. The vast amount of work done so efficiently is appreciated by your committee.

It is the hope of your committee that the industrial postgraduate course could and should become a yearly affair. Unless interest, as evidenced by a better attendance, can be assured, we doubt the advisability of repeating it next year.

We also want to thank Doctor Shanklin and his staff for the fine report of our meeting, through the special June issue of *THE JOURNAL*, on Industrial Medicine.

We also suggest to your delegates that insurance companies be asked to try and simplify the reports in order to save time.

We have also submitted to you, through the Executive Committee, a code of ethics. This we recommend for adoption after its having passed through the proper channel.

We have also asked Colonel Samuel Peck, Senior Surgeon, United States Public Health Service, and Doctor Spolyar to formulate a simple form for the reporting of occupational skin diseases to insurance companies, to be published in *THE JOURNAL* for your convenience.

E. S. JONES, M.D., *Chairman*,
JAMES H. CROWDER, JR., M.D.,
L. S. MCKEEMAN, M.D.,
A. G. KAMMER, M.D.,
J. C. BURKLE, M.D.,
CHARLES A. WELLER, M.D.,
L. W. SPOLYAR, M.D.,
THOMAS DOBBINS, M.D.,
H. C. WADSWORTH, M.D.,

(Continued on next page)

(Continued from preceding page)

A. P. HAUSS, M.D.,
J. C. ELLIOTT, M.D.,
SAMUEL KENNEDY, M.D.,
FRED B. WISHARD, M.D.,
IRA PERRY, M.D.,
ALFRED ELLISON, M.D.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The Council held one meeting, November 23, 1943, under the chairmanship of Dean Glenn L. Jenkins of Purdue University. The meeting was called for the purpose of determining the attitude of component associations, all of which were present, and in addition the Veterinary Association had been invited and was represented. Expression of opinion opposing the Wagner-Murray-Dingell Bill and socialization in general found harmonious unanimity from all participating groups.

Dean Jenkins called attention to other proposed legislation threatening the security and freedom of scientific professions. In addition to the Wagner-Murray-Dingell Bill, he cited the Kilgore Bill which would place scientific research largely under the heavy hand of government bureaucracy. The meeting proved a very valuable vehicle through which the kindred interests of the allied professions were clearly emphasized.

F. S. CROCKETT, M.D., *Chairman*,
PAUL A. GARBER, M.D.,
J. T. OLIPHANT, M.D.,
F. T. ROMBERGER, M.D.,
N. M. BEATTY, M.D.,
W. J. WRIGHT, M.D.

ANTI-TUBERCULOSIS COMMITTEE

House of Delegates,

Indiana State Medical Association.

Gentlemen:

A luncheon meeting of members of the state and county anti-tuberculosis committees was held during the ninety-fourth annual session of the Indiana State Medical Association, on Tuesday, September 28, 1943. Dr. Herman E. Hilleboe, senior surgeon and medical officer in charge of the

Tuberculosis Control Section of the United States Coast Guard and the United States Public Health Service, spoke on "Tuberculosis Control in Industry," illustrating his talk with 35 mm. film. The discussion was led by Dr. A. W. Elsten, assistant medical director of the Delco-Remy Division, Anderson, and Dr. Philip H. Becker, superintendent of the Lake County Tuberculosis Sanatorium, Crown Point. Following a general discussion an x-ray conference was sponsored by the Indiana Chapter of the American College of Chest Physicians. The meeting was well attended, about seventy-five being present.

The members of your committee met as guests of the Louisville Chapter of the American College of Chest Physicians, in Louisville, April 15, 1944.

The Anti-Tuberculosis Committee has been in correspondence with several of the county medical societies during the past year. A problem was presented by the St. Joseph County Medical Society regarding the clinical status of industrial workers with pulmonary tuberculosis. Several instances were shown where one physician would state that a patient had active disease and another physician would render an opinion that no hazard was present to his fellow workmen. Such problems have arisen in other localities. After a conference of your committee, it was decided that each case has to be solved on its merits. It was agreed that an individual with a positive sputum should not be working as there is danger of infection to others and the disease is not under control. Sputum examinations, a temperature record, blood sedimentation rates, and serial x-ray are important criteria for determining the condition of the patient.

The Indiana Tuberculosis Association is sponsoring a 35 mm. x-ray survey in industry. About ten thousand x-rays have been taken in Indianapolis, and a number of other sections of the state have contracted for them. The local tuberculosis associations are financing this work in cooperation with the various industries, the cost per film being fifty-five cents. The interpretation of these films has been undertaken by members of the Indiana Roentgen Ray Society and qualified chest specialists. The price agreed upon for interpretation is twenty-five cents per film. This work has the endorsement of your committee, and it is felt that many cases of clinical tuberculosis will be uncovered by this method. A report of the x-ray findings is sent to the family physician. The State Board of Health Tuberculosis Director has cooperated with the members of your committee, and the present plan of filing x-rays of rejected tuberculous servicemen is approved. Your committee also feels that the interpretation which is sent by the Tuberculosis Director to the family physician is a step in the right direction. These government x-rays of rejected servicemen are available to the family doctor on request.

Your committee recommends that its work be

continued because of the problems arising from the war examinations.

J. H. STYGALL, M.D., *Chairman*,
J. V. PACE, M.D.,
H. B. PIRKLE, M.D.,
R. C. MEYER, M.D.,
JAMES MCBRIDE, M.D.,
M. H. DRAPER, M.D.,
PHILIP H. BECKER, M.D.

COMMITTEE ON CONSERVATION OF VISION

House of Delegates,

Indiana State Medical Association.

Gentlemen:

During the past year the work of the Committee on Conservation of Vision has been limited to the completion of two projects. We held our annual Conservation of Vision breakfast at the Claypool Hotel, Wednesday, September 29, 1943, with Harry S. Gradle, of Chicago, as our guest speaker for the second consecutive year.

At the breakfast meeting which we are planning for this year, to be held at 7:30 Wednesday morning, October 4, at the Indianapolis Athletic Club, Dr. C. W. Rutherford, of Indianapolis, will be our speaker. Doctor Rutherford's work as State Supervising Ophthalmologist of the State Department of Public Welfare has provided him with a large fund of information regarding the causes of lost vision in our own state, and his comments regarding sight conservation, based upon this knowledge, will be of great value to all of the Indiana ophthalmologists. The attendance at these breakfasts has been consistently large, encouraging us to continue them for the benefit of the men who are especially interested in ophthalmology.

Our other chore consisted of obtaining the papers for the annual Conservation of Vision number of our state medical JOURNAL. As in previous years, we attempted to secure papers which would be interesting to the men in other branches of practice than ophthalmology, with the idea of keeping our fellow practitioners informed regarding new developments and reminded concerning the well-established principles of sight conservation.

R. J. MASTERS, M.D., *Chairman*,
J. V. CASSADY, M.D.,
O. T. ALLEN, M.D.,
M. G. EREHART, M.D.,
EUGENE L. BULSON, M.D.

COMMITTEE ON HARD OF HEARING

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The Committee on Hard of Hearing has started at the bottom of this new and extensive field. As has been pointed out before, the real conservation problems for children occur before the age of five years, during the period when the child first encounters infections such as meningitis, measles, scarlet fever, and tonsil and adenoid infections. All efforts should be used to protect the ears against noise, the same as eyes are protected against light. Proper medication and care also will insure retaining as much hearing as possible. After the first few years of life have left their mark on hearing, the problem then becomes one of rehabilitation, which we will come to later.

So far as adults are concerned, we hope that post-war planning will include reduction of noise, particularly in plants where machinery is used. Not much has been done as yet to provide for such help.

For the relief of stricken children separate classes along with lip reading instruction are beginning to appear in our public schools. As of the close of last year's school, the following centers have state support for special classes: Bloomington, Boone County (Center Township), Lebanon, Connersville, East Chicago, Evansville, Gary, Indianapolis, Kokomo, Monroe County (Benton Township), Muncie (Burns and City), New Albany, South Bend, Sullivan (Cass Township), Terre Haute, Vincennes, Washington, and Whiting.

When a child cannot get along in public school, he becomes eligible for the Indiana State School for the Deaf. There is no institution in the state to care for the deaf-blind, and no other school for the deaf. This institution is maintained by the state and has about four hundred children enrolled. They range in age from five and one-half to eighteen years, and are kept at about ten pupils to the class. Shortage of teachers (four-five) causes some crowding at present. These children are taught lip reading so that at the end of the first year they have a vocabulary of about three hundred words. At the end of grade school about ten percent are capable of going on to high school. All are prepared, however, to serve as better citizens and enjoy life more fully than if they went out without being able to communicate with their fellowmen.



Bonds buy Bombs for the Air Force



With your kind indulgence we hope to gather more information by surveys, so that the hard-of-hearing and deaf may profit.

J. KENT LEASURE, M.D., *Chairman*,
O. T. ALLEN, M.D.,
E. E. HOLLAND, M.D.,
M. G. EREHART, M.D.,
B. D. RAVDIN, M.D.,
K. L. CRAFT, M.D.

WAR PARTICIPATION COMMITTEE

House of Delegates,

Indiana State Medical Association.

Gentlemen:

This is the fifth annual report of this Committee to the House of Delegates. Through the foresight and wisdom of the 1939 session, an M-Day Committee was provided, eventuating in what is now the War Participation Committee which has carried on the activities of the Procurement and Assignment Service for Physicians. Each year it was thought that these activities would diminish. We consistently refused to accept clerical help or financial assistance from the War Manpower Commission and the Directing Board of Procurement and Assignment Service. It was felt that furnishing our own clerical help and quarters would be in part the association's contribution to the war effort. Last year we accepted replacement of supplies we had used and reimbursement for postage. The volume of business remains large. Therefore, this year we are asking for a typist-stenographer, a typewriter, and allowance for rental space in the association headquarters. It is probable that the Procurement and Assignment Service will be projected into the post-war demobilization period.

There are 54,096 physicians in the armed forces. The number of physicians in service from Indiana remains at the level of last year, about 1260. Twenty-nine physicians have been certified from practice and commissioned during the last year; largely residents and interns have entered service, and the number is to some extent offset by the fifty-one Indiana physicians who have been returned to civil life, having been separated from service.

Several "critical" areas exist in the state, notwithstanding the fact that the question of allocation has received much attention. We have successfully allocated a number of physicians. The reasons for our inability to cope with the situation in some instances are:

1. We have no authority over those physicians rejected by the armed forces, and will not have until a general Service Act is passed by

Congress, which is unlikely. There is no other source of replacement personnel.

2. Physicians elect to remove to another location; also they become disabled or die.

Recently we received from the Directing Board data purporting to show the ratio of physicians per 1,000 population. A more flattering picture is depicted than the facts justify. This information is broken down into counties, giving the total population and the number of active physicians. To illustrate why exception is taken, one example is cited. In a given county the population is stated as 20,000 whereas the county seat alone has 18,000, and thirteen physicians are listed, eleven rated as active. By active it is presumed that they are 100 per cent effective. In this county it is known that one physician is older, has hypertension and chronic nephritis, and is disabled; one has cancer; one has had a cerebral hemorrhage; one is sixty-three, with an impaired heart; one weighs over three hundred pounds; one will accept nothing but industrial work; and two others do not handle a large practice. In a nearby village is a father and son—the father is seventy-five years of age.

Over the state are physicians who are rated as active who devote their time to defense plants or institutions, to teaching or public health service, and mean little to the general medical care of the civilian population.

During the last year much time has been devoted to the question of interns and residents in an attempt to maintain sufficient internal staff to enable hospitals to function. Many hospitals have labored under serious handicaps. Beginning October 1, 1944, it is hoped that the whole situation will have been satisfactorily adjusted.

Selective Service is no longer deferring pre-medical students. This question demands earnest consideration. The surgeons general of the armed forces remain adamant against releasing medical officers to return to civilian practice. It is probable that several years will elapse before any considerable number of physicians will be discharged from service, since we probably are going to retain a considerable Army and a very large Navy. The Army will remain larger than the pre-war establishment and will be called upon to detail medical officers to the occupied countries, and to United States veterans hospitals—the only way in which veteran facilities seem able to procure medical personnel. The number thus detailed will be increasingly greater for several years as demobilization proceeds. Granting that the war in Europe may end this year, it is likely that the war with Japan will extend well beyond that period.

The Veterans Administration has issued an appeal from General Hines' office that the state association in collaboration with veterans' organizations, such as the American Legion, to assist it by appointing a physician or group of physicians in each county to make examination reports on the discharged soldier, to determine the need for hos-

pitalization and physical status for other purposes. Already it is beyond the Veterans Administration's ability to keep current, and the load will continue to mount. The Governor is setting up an agency, looking toward the rehabilitation of returning servicemen, and this agency might well have a medical section.

Indiana has only four physicians who refused to apply for a commission when declared available and were asked to apply. Others who refused soon found it expedient to apply.

In Indiana we are willing to stand on our record. Mistakes were inevitable. Were we to cover the same ground again, it is probable the same mistakes would be made. Decisions have always been made on the basis of what was thought to be just and equitable—no other.

A monthly news letter continues to go to all Indiana physicians in service, sent V-mail to those in foreign service, and it is recommended that this be continued.

Attention is directed again to the question of a state association rotating fund to assist physicians returning from service.

Attention is also directed to the possibility that on demobilization many returning medical officers will prefer to locate in the larger centers, and others will tend to enter the fields of specialization. Thus, it may be that numerous communities having had prior to the war one or even two physicians will be left with no physician.

To meet the problem requires thought and early consideration; otherwise the United States Public Health Service will be compelled to meet the need.

One solution might be to allocate a young graduate to such a community after one year of internship on a rotating basis, giving credit for one year as a junior or senior resident.

During the chairman's prolonged absence from the office, Doctor John R. Newcomb has carried on in a wholly efficient manner. A debt of gratitude is due him. We again express our sincere thanks to the personnel in Mr. Hendricks' office.

C. R. BIRD, M.D., *Chairman*,
J. R. NEWCOMB, M.D., *Vice-chairman*,
W. M. MILEY, M.D.,
CARLETON B. MCCULLOCH, M.D.,
C. C. TUCKER, M.D.,
MAJOR GLEN W. LEE, M.C.

COMMITTEE ON PHYSICAL THERAPY

House of Delegates,

Indiana State Medical Association.

Gentlemen:

In our annual report of 1943 we announced that the infamous Limitation Order L-259 had just been foisted upon an unsuspecting medical profession by the War Production Board. This edict prohibited

the manufacture of and sale to ethical physicians all types of physical therapy equipment accepted by the Council on Physical Therapy of the American Medical Association. This equipment could be manufactured and sold *only* to the armed forces and the Government-fostered LEASE-LEND. You will recall that we announced that we had started our fight to preserve the rights of civilian physicians by contacting both United States senators from Indiana as well as each member of the Indiana congressional delegation, most of whom were willing to cooperate with us.

We are pleased to announce at this time that in spite of the pessimistic attitude of some of our confreres the first round of the fight has been won. L-259 has been amended to permit the manufacture of and sale to civilian doctors the following modalities: electric bakers; fever cabinets; galvanic generators; magnetic field (inductotherm) generators; medical diathermy units; passive-vascular exercise equipment; surgical diathermy units; ultraviolet radiation generators, and whirlpool baths. Electric bakers, infra-red generators and ultraviolet radiation generators may be rented or sold to the public on a written prescription of a "medical practitioner licensed to use physical therapy equipment."

Your committee feels that there are two "jokers" in this amendment:

1. What is meant by a "medical practitioner licensed to use physical therapy equipment?" So far as we know, no doctor of medicine has or needs a license to use physical therapy equipment. Do they mean, or include, chiropractors, osteopaths, naturopaths, et cetera?

2. Are replacement parts, especially tubes for short wave diathermy units available? You will recall that the War Production Board informed us very definitely (as reported in our 1943 report) that these tubes were practically identical with those used in the electronic units of our armed forces, and hence *would not* be made available for civilian use.

Several things have been uncovered in our fight to date, and merit your serious consideration:

1. Certain government agencies and bureaucracies are definitely *against* organized medicine as it exists today. They can be expected to make every effort to regiment and socialize medicine. Their methods will be clever and devious. All committees, therefore, should be on their guard.

2. Certain national medical associations have been so badly frightened by recent defeats that little assistance can be expected from them at this time.

3. There exists a very serious lack of cooperation between state medical committees and national medical organizations. This has been especially proved by the fact that this committee has been unable to obtain any authentic informa-

tion on the Baruch Committee on Physical Therapy as to its intentions and personnel selected to work in this state.

RECOMMENDATIONS

1. Your committee recommends that every effort be made by the officers, the delegates, and the counselors of the Indiana State Medical Association to induce the American Medical Association, the American Congress of Physical Therapy, and other national medical organizations, to recognize and cooperate with our various state committees.

2. We reiterate our recommendation of 1943 (which was accepted by the House of Delegates, and then nothing further done about it) that at each annual meeting of the Indiana State Medical Association one paper on Physical Therapy be presented by a nationally-known authority, and that at least one discussant be selected.

3. Your committee wishes to recommend that the House of Delegates attempt to obtain authentic and definite information on the Baruch Committee on Physical Therapy, said information to include:

(a) The aims and intentions of this committee in Indiana.

(b) The personnel selected to carry out the work of this committee in this state.

APPENDIX

Your committee wishes to express its sincere appreciation to Thomas A. Hendricks and his efficient staff for their invaluable assistance, without which we certainly could not have gotten as far as we have.

N. H. PRENTISS, M.D., *Chairman*,
H. W. SMELSER, M.D.,
ANNA L. GOSS, M.D.,
GEORGE A. OBERY, M.D.

* * *

MINORITY STATEMENT

I feel that the above report is much too vociferous and vitriolic to appear as a committee report.

No matter what our personal feeling may be with regard to the matters mentioned therein, it is my judgment that no good is accomplished by vituperation.

I would, therefore, prefer that my name not appear in approval of this report as written, especially so because I cannot agree with the substance; in fact, I have no information confirming the substance.

I fully appreciate the energy and competence of our chairman and his desire for more cooperative efforts in the field of physical medicine; in such efforts I am willing to cooperate fully.

DON D. BOWERS, M.D.

COMMENTS OF THE CHAIRMAN AND THE SECRETARY OF THE COUNCIL ON PHYSICAL MEDICINE OF THE AMERICAN MEDICAL ASSOCIATION ON THE ANNUAL REPORT OF THE COMMITTEE ON PHYSICAL THERAPY OF THE INDIANA STATE MEDICAL ASSOCIATION—JULY, 1944.

It is noted that the committee has criticized the Limitation Order L-259. This matter, as stated in the report, is being adjusted. The order has been revised and it is less drastic, and by fall apparatus should be available to a limited extent.

The chairman of the Council on Physical Medicine, Dr. Frank H. Krusen, member, and its secretary have made repeated attempts to ease the replacement problem. Progress has been made and replacements should be more accessible in the near future, if not already.

As interpreted by the writers, the statement "medical practitioner licensed to use physical therapy equipment" means that chiropractors, osteopaths, naturopaths and other cults are permitted to use physical therapy equipment for therapeutic purposes, provided they are licensed to do so by the state in which they reside. The practice of medicine is regulated by the states themselves, and the order in question does not make any attempt to regulate the practice of medicine in the individual states.

Under the caption "Recommendations" there are three items on which the following comments are offered:

1. The Council on Physical Medicine desires to cooperate with the Committee on Physical Therapy of the Indiana State Medical Association, and welcomes the opportunity to do so.

2. The Council on Physical Medicine stands ready to assist the program committee of the Indiana State Medical Association, and any other state, by giving (1) a list of speakers on physical medicine; (2) making available printed material on physical medicine; (3) loaning moving picture films, and (4) loaning slides for class instruction.

3. The official report on the Baruch Committee on Physical Medicine is available. The aims and intentions are clearly set forth in the report. Further information may be had by writing to officials of the committee.

There are other problems mentioned in the committee's report, but they do not come under the purview of the Council on Physical Medicine. It is believed that the state society can best handle them.

The Council on Physical Medicine will be interested to learn more about the activities of the Committee on Physical Therapy in the State of Indiana, and will welcome further opportunities to cooperate with it.

JOHN S. COULTER, M. D., *Chairman*,
HOWARD A. CARTER, *Secretary*.

MEDICAL RELIEF COMMITTEE

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

I. GENERAL PRINCIPLES

A. We affirm the previous policies of the Indiana State Medical Association and the Medical Relief Committee that our goal is "good medical care for all the people."

B. The Medical Relief Committee reiterates the belief that the medical profession of Indiana will accept the responsibility of providing good medical care for all of the people of Indiana.

C. We believe that the continuation of a policy of free choice of physician and a voluntary form of medical service to the people are fundamentals in any plan to attain the goal of "good medical care for all of the people."

D. We further believe that the standards of such care can only be made good and ultimately made better by responsibilities entrusted to an alert, skilled, and trained medical profession—a profession that will apply the fruits of scientific medicine and a broadened social conscience to future problems as they arise.

II. HOME RULE

The committee believes that the problems of the indigent and near medically-indigent can best be ascertained in the immediate locality where they are met. It is our belief that local officials, local agencies, and local physicians can best investigate and evaluate the immediate needs of the community.

Differing economic conditions of widely-scattered communities make it seem unlikely that one uniform state-wide plan would satisfactorily apply to communities of diverse complexions.

Present-day hospital shortages make it seem likely that local hospitals could be used to advantage under the direction of local duly-licensed and qualified physicians. It goes without saying that consultative or skilled specialized talent could likewise be secured through the same means.

It does seem that efficient local "home rule" should be conducted to the end that a broad basic common-sense standard of state-wide care could be established by periodic conferences of representatives of widespread units.

In the event that local needs exceeded local resources, appeal could then be made by local officials and local physicians to higher government, whether it be county or state. In this way adequate medical facilities could be secured and the state-wide basic standard be attained.

III. COUNTY MEDICAL AID

Expense for medical aid should be borne by the county after the expense incurred has been adequately appraised by integral units. Should the

sum total of integral units exceed the resources of the county budget, appeal could be duly made to the state through its proper agencies.

IV. STATE LAWS

Our state laws are framed with the purpose of guaranteeing medical aid to those deemed worthy and in need of such services. In some instances the application of state laws to unusual conditions of medical needs are not clearly defined. The existing laws of Public Assistance for Medical Aid enacted in 1941 and revised in 1942 and 1943 do not dispense with the need of local responsibility of officials and private agencies of meeting needs of medical service.

V. IMMEDIATE PROBLEMS

A. The profession is now extending medical services in many ways under the Division of Public Assistance of the Department of Public Welfare. Since we cannot at this time foresee legislation which will affect these departments, we can only recommend that the Welfare Department operate in behalf of local needs with the friendly and skilled advice of local officials and local professional people.

B. Health legislation which may be proposed by the Federal Government cannot be anticipated. Only mature experience of local medical and governmental units can supply knowledge of needs, and these needs can best be incorporated in any federal medical bills through knowledge transmitted to the duly-elected representatives of the people. We urge that such information be kept constantly at the disposal of our constitutional representatives.

C. Voluntary health and hospital insurance plans loom large as possible economic moves which may vastly affect many of our citizens and, in turn, the medical profession. We should stand ready to constructively aid and guide these projects.

VI. RECOMMENDATIONS

A. It is the duty of every physician of every county medical society to know as much as possible about the relief situation in his own township and county.

B. If local governmental units are inadequate in personnel for proper investigation of local needs, the medical profession should make this inadequacy known in a friendly and cooperative manner.

C. Local physicians should acquaint themselves with the tax basis and budget provided for local medical aid needs.

D. Every physician should know with reasonable accuracy the expense incurred in the conduct of his practice, and this knowledge will serve as a fair means of adjudging fees submitted for medical aid.

E. We of the profession should have a friendly and courteous relationship with officials and agencies who administer poor relief in our communities. We should have a sympathetic understanding of the task they are endeavoring to perform.

VII. COMMENTS:

It is the belief of the committee that under the duress of war, with the absence of many of our members in service and with the tremendous load placed upon remaining civilian medical facilities, that we of the profession of Indiana are keeping faith with the ideals set forth above.

Furthermore, we believe that if our policies are enthusiastically supported by the profession at large, and if each physician will keep vigilant and alert to the vast changes confronting the social order, we can continue to maintain the sound basis of free medical practice and the ultimate goal of "good medical care for all of the people."

EUGENE F. BOGGS, M.D., *Chairman*
J. L. WYATT, M.D.
CLAUDE S. BLACK, M.D.
ALFRED ELLISON, M.D.
E. O. ASHER, M.D.
JESSE FERRELL, M.D.
R. W. WATERTON, *ex-officio*.

* * *

SUPPLEMENTARY REPORT

For years the American Medical Association and practically all physicians who understand the implications involved have advocated, in cases where a third party pays the expense of medical care, that such funds be paid to the patient so that he in turn may reimburse the doctor of his choice; the theory being, of course, that when the third party pays the doctor directly this third party is ultimately going to dictate the policies under which such services are to be rendered. It is indeed a form of socialization of medical practice. This is especially objectionable where the government is the third party. It is less so when an insurance carrier, for example, is the third party. In our meetings with the State Department of Public Welfare it was brought out by the administrators of this program that more than half of our county medical societies have requested that the funds paid out under their jurisdiction be paid directly to the physicians. I am sure that many of us feel that this is unfortunate and that this practice will ultimately help to make the complete socialization of medicine not only easier for the government to effect but for the doctors to accept. We should appreciate that what might mean the gaining of a few dollars now may mean the loss of medical independence in the future.

It is my feeling that the report of our committee should take cognizance of this trend and go on record as being opposed to it.

ALFRED ELLISON, M.D.

Red Letter Days—
October 3, 4, and 5

COMMITTEE ON RURAL MEDICAL CARE

House of Delegates,

Indiana State Medical Association.

Gentlemen:

On April 12, 1944, President Oliphant appointed a committee to work with the Farm Security Administration in the medical phase of its Rural Rehabilitation Program. The three counties operating medical care programs in Indiana this year are: Franklin, Wells, and White. Past experience has shown the value of prepaid medical care to low-income families undergoing rehabilitation with Federal funds received through the Farm Security Administration. In many states the development of this plan has received the benefit of advice from committees appointed from the respective state medical associations.

This year Indiana has inaugurated a similar effort at cooperation. So far we have not had a committee meeting, although one of us, Dr. H. N. Smith, of Brookville, was able to participate in a study, first hand, by visits with families in Crawford and Orange counties to learn the health needs of Farm Security Administration clients.

F. S. CROCKETT, M.D., *Chairman*,
H. N. SMITH, M.D.,
VERNE L. TURLEY, M.D.,
O. G. HAMILTON, M.D.,
J. P. GALBRETH, M.D.

* * *

ADDENDA

This is my report of my trip with the members of the Farm Security Administration on Rural Medical Care.

On June fourth I met Dr. J. A. McElligott, the Regional Medical Officer; Mr. Leader, who is the District Manager of the Farm Security Administration; and a Professor of Sociology from Indiana University. We drove to English, Indiana, by car and met the local Farm Security manager. In his car we traveled over parts of Orange and Crawford counties. Both counties were very hilly and had very little good farming land. Due to the type of people and the type of land, they did well to obtain the necessary things of life. When serious sickness appeared in the family, they had a great deal of difficulty in obtaining proper medical care because of lack of finances and the great distances from the hospitals.

We interviewed a number of the people who had procured loans for medical care. Most of these had some chronic ailment. The money they received to pay for their operations and hospital bills was adequate, but they were having considerable difficulty in repaying the loan.

In conclusion, I believe that better medical care should be secured for these people and that an effort should be made to secure different occupations, as

the farm land is so poor that obtaining the necessary things of life and medical care is impossible.

The Farm Security Administration has been doing some good work in these counties. In Orange and Crawford counties the plan of financing medical care has, I believe, been very beneficial. They have educated people to the necessity of screendoors and better water supplies, and they have helped in serious illness where no other help was available.

H. N. SMITH, M.D.

OPA MEDICAL ADVISORY COMMITTEE

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The OPA Medical Advisory Committee has had and continues to have a great deal of work.

During the spring of 1943 our committee asked for a committee of dietitians from the Indianapolis hospitals to work with us in an attempt to formulate maximal diets for some of the more common diseases. The dietitians kindly consented to assist. They laboriously computed diets for several days, adhering to sets of figures we all considered maximal for that group of diseases. Following these meetings we published in THE JOURNAL of the Indiana State Medical Association what we considered maximal figures¹ both for rationed and unrationed foods. Our figures were used by the Indiana state OPA office as a guide for allotting supplementary foods.

During the subsequent months the state OPA office and the county branches for food rationing made decisions based upon our figures. The food allotments were adequate and were handled uniformly throughout the state. Our set-up was sought by other states and was gaining at least a sectional prominence, if not a national one. Mr. Paul H. Moore, the state director of Food Rationing, had been able to supervise rationing with the aid of untrained voluntary and unpaid workers, and did it with but few complaints.

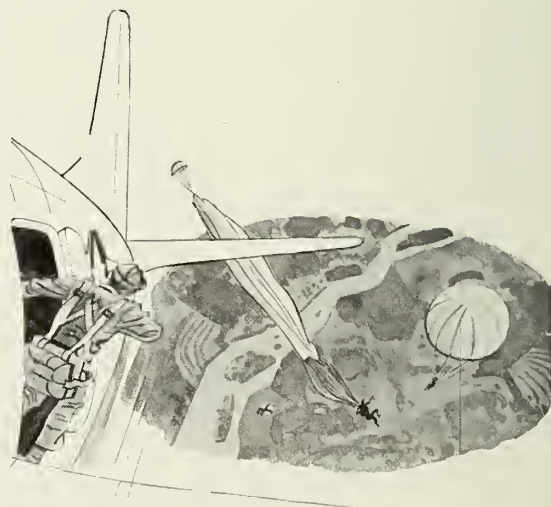
Food Rationing in Wartime,² the Recommendations of the National Research Council, was published October 16, 1943. In compiling figures and making recommendations for maximal allowances, the Research Council suggested lower figures for processed foods than we had listed in our maximal diets, and they deducted some other foods which they took for granted everyone could obtain. Early in 1944 the Washington office of OPA for food rationing accepted the National Research Council's

figures for maximal diets and issued directives to the various state OPA offices. That directive from Washington caused us much grief. Hundreds of special food requests piled into the state office. Mr. Moore and your committee hardly knew what to do about them. The committee could not take time to pass individually upon all of them.

At a called meeting we listed most of the diseases that should demand supplementary ration points and indicated, for Mr. Moore's guidance, the amount of food that should be allowed for each in-so-far as the national OPA directive would permit. Although this grouping of many diseases has proved very helpful, there are still too many appeals to the state committee. Even though our committee has been as liberal as the national OPA permits, there are some instances where the allotted diet may not be quite adequate for the needs of all patients.

On the whole, the committee has endeavored to serve both the medical profession and the government. We have tried sincerely to see that every deserving case had a just solution. Hundreds of cases have had our individual attention in the course of the year. We realize that we may have made some mistakes, but we doubt if anyone actually has suffered from our decisions. The members of the Indiana State Medical Association have realized that *we are at war* and have been reasonable in filling out food applications, but there are still some physicians who either wish to feed all the relatives or are so poorly informed on food requirements that they send in ridiculous requests. If we have erred, we are sorry. Our limitations are such that we can not grant everything that is requested.

C. L. RUDESELL, M.D., *Chairman,*
WILLIAM M. DUGAN, M.D.,
REUBEN A. SOLOMON, M.D.



*They are bailing out for you—Are you buying Bonds
for them?*

¹ Extra Ration Points for Special Diets, *J. Ind. State Med. Ass'n.*, 36:312, (June) 1943.

² Food Rationing in Wartime, Recommendations of the National Research Council, *J.A.M.A.*, 123:422, (Oct. 16) 1943.

Woman's Auxiliary

TO THE

INDIANA STATE MEDICAL ASSOCIATION

STATE OFFICERS

President, Mrs. James W. Baxter, Jr., New Albany
 Councilor, Mrs. Arnold H. Duemling, Fort Wayne
 President-Elect, Mrs. Frank M. Gastineau, Indianapolis
 First Vice-President, Mrs. R. W. Kepler, LaPorte
 Second Vice-President, Mrs. H. M. Rhorer, Kokomo
 Third Vice-President, Mrs. Harry M. Shultz, Logansport
 Fourth Vice-President, Mrs. Irvin H. Scott, Sullivan
 Treasurer, Mrs. A. W. Ratcliffe, Evansville
 Recording Secretary, Mrs. E. T. Stahl, Lafayette
 Corresponding Secretary, Mrs. John F. Habermel, New Albany
 Parliamentarian, Mrs. Charles F. Voyles, Indianapolis
 Historian, Mrs. U. G. Poland, Muncie

CHAIRMEN OF STANDING COMMITTEES

Archives, Mrs. William E. Tinney, Indianapolis
 Bulletin, Mrs. Ernest O. Nay, Terre Haute
 War Participation, Mrs. M. B. Van Cleave, Terre Haute
 Finance, Mrs. C. E. Munk, Kendallville
 Hygeia, Mrs. George R. Dillinger, Thomasville, Georgia.
 Legislation, Mrs. F. B. Wishard, Pendleton
 Organization (Northern), Mrs. Herbert A. Ray, Fort Wayne
 Organization (Southern), Mrs. Frank M. Gastineau, Indianapolis
 Press and Publicity,
 Mrs. Arthur B. Richter, Chairman, Indianapolis; Mrs. Emmett
 B. Lamb, Indianapolis; Miss Lucy E. Schuler, Kokomo
 Program, Mrs. E. N. Mendenhall, Fort Wayne
 Public Relations, Mrs. W. F. Hughes, Indianapolis
 Pioneer Memorial, Mrs. O. G. Pfaff, Indianapolis

COUNTY PRESIDENTS

Allen: Mrs. Emor L. Cartwright, Fort Wayne
 Carroll: Mrs. C. L. Wise, Camden
 Cass: Mrs. Harry M. Shultz, Logansport
 Clark: Mrs. R. G. Burman, Jeffersonville
 Delaware-Blackford: Mrs. U. G. Poland, Muncie
 Elkhart: Mrs. A. C. Yoder, Goshen
 Floyd: Mrs. Samuel M. Baxter, New Albany
 Hancock: Mrs. J. E. Ferrell, Fortville
 Howard: Mrs. G. N. Druley, Kokomo
 Lake: Mrs. Samuel J. Petronella, East Chicago
 LaPorte: Mrs. Louis Moosey, Union Mills
 Madison: Mrs. W. Elsten, Lapel
 Marion: Mrs. Gerald W. Gustafson, Indianapolis
 Marshall: Mrs. Homer Burke, Bremen
 Northeastern Indiana Academy of Medicine: Mrs. C. E. Munk,
 Kendallville
 Orange: Mrs. R. E. Baker (Vice-Pres.), Orleans
 Porter: Mrs. E. H. Miller, Valparaiso
 St. Joseph: Mrs. M. J. Thornton, Bremen
 Sullivan: Mrs. Marion H. Bedwell, Sullivan
 Tippecanoe: Mrs. George R. Donahue, Lafayette
 Vanderburgh: Mrs. A. W. Ratcliffe, Evansville
 Vigo: Mrs. Maurice B. Van Cleave, Terre Haute

REPORTS OF OFFICERS AND COMMITTEES

MRS. JAMES W. BAXTER, JR.

President's Report

It is indeed a privilege to be able to express, in

this report, my sincerest thanks to the women of Indiana who have so loyally carried on the Auxiliary work this year. I feel that this now-existing feeling of cooperation and fellowship will continue to be a motivating force in attaining even greater success in the years to come.

Indiana was honored by having the National President, Mrs. Eben J. Carey, at the annual meeting in Indianapolis, in September, 1943. Her charm and inspirational messages at that time gave us courage and a keen desire to carry on with the important tasks ahead.

Auxiliary activities began October first, very enthusiastically, with the first state board meeting in Indianapolis, November 4, 1943, well attended. Mr. Thomas A. Hendricks, executive secretary of the Indiana State Medical Association, gave us an excellent explanation of the Wagner-Murray-Dingell Bill and suggestions for the practical application of our efforts in working with legislative measures.

The second state board meeting was held on May 3, 1944, with twenty-six members present—a larger number than has attended a board meeting for several years. At this meeting a special committee presented recommendations for some important changes in our state organization, which will make our year correspond with the national organization. These proposed changes give evidence of a progressive organization and a courageous determination to keep our auxiliary abreast with the times.

We were happy to welcome into our state family, this year, two new county units. We now have twenty-two auxiliaries, with a total membership of 771, which number was exceeded only once before—in 1942—before the Procurement and Assignment.

Following the example of last year, we again issued Program Kits to our county units, which gave in compact form the outlines and suggestions of the state officers and chairmen, together with a complete list of names and addresses of all members of the State Board of Directors. Also contained in the Kits were "Highlights" of the National board meeting, held in Chicago, November 19, 1943.

A keen interest has been shown in matters of legislation in the state, and some very outstanding meetings have been held for the purpose of discussing the Wagner-Murray-Dingell Bill. Such outstanding speakers as Dr. Morris Fishbein, of the American Medical Association, and Mrs. Rollo K. Packard, national chairman of War Participation, were speakers in the state, with audiences numbering five and eight hundred at some of the meetings. The Speakers' Bureau also provided men from our state association for other meetings.

We feel that war participation activities have been carried on in a satisfactory manner. Some of our auxiliaries have paid the dues of their members who are away from their established

homes. Other groups, particularly in the defense areas, have made especial effort in welcoming the new doctors' families in their communities. One busy president found time to edit a newsletter which was sent regularly to their members in other cities, keeping them in constant touch with activities at home. Still another group edited bulletins for the doctors and nurses in service. Other activities have been as follows: contributions for hospital equipment; Red Cross; Tuberculosis Association; Women's Field Army for the Control of Cancer; occupational therapy; recruitment of nurses; doctors' aides; U.S.O.; collection and shipment of old jewelry for barter purposes; and discussion of health and educational topics. All reports sent to the state press and publicity chairman for publication in the state journal have indicated constructive and worthwhile programs. For the generous amount of space given to the auxiliary in the state journal, we are indeed grateful, for it provides a means for all doctors' wives, whether or not they are members of an auxiliary, to keep informed regarding the activities of the county units and the state organization.

An almost countless number of hours have been given by our members to Red Cross, Civilian Defense, and other phases of war work. Doctors' wives have provided leadership in these activities, such as chairmen of Red Cross Home Service, Nurses Aides, Staff Assistance, Motor Corps, Blood Bank, Surgical Dressings, and Knitting; and in Civilian Defense: Ration Board work, sale of War Bonds, et cetera. Auxiliary members as individuals or groups also gave much time to the drive of the Women's Field Army for the Control of Cancer.

Hygeia and *Bulletin* subscriptions were solicited during the year. Gift subscriptions to *Hygeia* were again given to schools, parochial and public—regardless of race or creed—and to libraries and hospitals.

Many of our county units have cut down or eliminated entirely the customary social meetings when the need required such action, and instead had educational meetings, discussing health topics. We have stressed the idea of having monthly meetings instead of quarterly meetings, which has been the case in some counties, and a number have complied with this request. However, in several of the sparsely-settled communities monthly meetings have not been possible because of transportation, but those auxiliaries paid their dues, and the members worked as individuals in their communities and have kept alive the interest of the auxiliary in a most commendable manner.

Much to my regret, it was possible for me to visit only six of the county auxiliaries; however, on some of those visits we were successful in arranging group meetings so that twice that number of auxiliaries were actually contacted. It was an inspiration to meet the women personally, for it is because of them that the work has been carried on.

Upon the recommendation of Mrs. Arnold H. Duemling, Councilor, our state board bought a state

president's pin and a pin for each of the past presidents.

With the enthusiasm and interest shown during this year of turmoil and anxiety, I feel that auxiliary work is deeply rooted in Indiana, and that we have a very bright and interesting future when the world is once more at peace. Let us resolve now to have a share in making that peace by being as active in post-war activities as we have been in our united effort to attain victory.

For whatever degree of success we have attained this year, I give worthy credit to our National board members for their help and cooperation; to our state advisory council; to the executive secretary of the Indiana State Medical Association; and to the entire membership of the Board of Directors of the state auxiliary. I am most grateful for the opportunity of having served as president this past year. The contacts and associations with all have indeed been a very pleasant experience.

War Activities Committee

MRS. M. B. VANCLEAVE, *Chairman*

Almost a countless number of hours was spent by our auxiliary members in various phases of war work. Although not all of this work was done as an auxiliary project, it was done by doctors' wives through the various recognized, already-established, war relief agencies. One of the projects, the recruiting of United States Cadet Nurses, was a special effort of our national organization. Our Indiana auxiliaries assisted in recruiting one hundred eighty-three nurses. The largest number of hours, 37,827 hours, which is a report of only a few counties, were given to the Doctors' Aide Corps.

The value of the work being done by the Woman's Auxiliary speaks for itself, as evidenced by a letter written by Dr. Robert H. Wiseheart, of Lebanon, and published in *THE JOURNAL*, in which he states that while he was assembling supplies for the first American planes to be operated out of Russia he came across some bandages which had been packed in Lebanon by his wife.

Legislation

MRS. FRED B. WISHARD

There is evidence of increased interest in medical legislation. The county units have taken seriously the recommendations made by the state legislative committee for the current year.

In several counties outstanding programs have been brought before the public. Prominent and qualified speakers secured through the State Speakers' Bureau and also speakers from the American Medical Association have addressed large audiences on medical legislation.

County units are still urged to study the plan of pending and proposed legislation on Health, State, and Federal problems.

As state legislative chairman, I have received and studied the Legislative Bulletins sent to me from the American Medical Association and the state office. I have attended all stated meetings and have kept in contact with each county by correspondence. Because of limited means of transportation, I have been unable to visit county auxiliaries.

We must be alert at the time of the coming election and try to elect the men best fitted to promote our interests in the next session of the General Assembly in Indiana.

Organization (Northern)

MRS. HERBERT A. RAY, Chairman

It has been a difficult year in which to go foraging for new laurels, chiefly because of the gasoline shortage. Very many of our counties in northern Indiana are almost depleted of doctors' wives, many having gone to various camps where their husbands are serving.

Fort Wayne has a very strong organization, not only composed of Allen County but some two or three adjoining counties meet with us, thus making a very large and strong attendance at our meetings.

I feel that other counties will organize, and trust that the time is not too far distant when peace and unity may again prevail.

Organization (Southern)

MRS. FRANK M. GASTINEAU, *Chairman*

Our state auxiliary family was enlarged by the addition of two new members this year. Although your chairman does not take credit for having organized them, she takes pride in announcing their arrival. Their names are Hancock and Clark. Appropriately, these additions came the first of the year. Mrs. J. E. Ferrell, of Fortville, is the president of the Hancock County group, and Mrs. R. G. Burman heads the Clark County Auxiliary.

Program

MRS. E. N. MENDENHALL, *Chairman*

An outline of suggested topics for Auxiliary meetings under the headings of Social, Educational, Legislative and Public Relations Activities was prepared and presented to the Advisory Council of the Auxiliary to the Indiana State Medical Association for approval in the summer of 1943. This outline was given to the various units in the State Kit.

Through a questionnaire presented to the units after April 1, 1944, the following information concerning program activities was gleaned:

Twenty-two county units were contacted.

Eighteen county units responded.

Seven county units, including Floyd, Lake, Madison, Orange, St. Joseph, Tippecanoe and Vigo, did not respond.

Eleven units reported a total of twenty-seven social meetings.

Ten units reported a total of twenty-five educational meetings.

Eight units reported thirteen legislative meetings.

Four units reported eight public relations meetings.

All units were either as units or as individual members actively engaged in all phases of Red Cross and Civilian Defense work.

One unit recruited and pledged four nurses' aides—a project sponsored by the national organization.

Press and Publicity

MRS. ARTHUR B. RICHTER, *Chairman*

This committee wishes to thank the county presidents and publicity chairmen for their cooperation during the past year. Every month county reports or items of interest to the auxiliary were published in THE JOURNAL. Resumes of the business of all board meetings were printed. The annual reports of all county presidents and committee chairmen were compiled for publication. We will contact local newspapers for publicity for the state convention next October.

All of the Indiana state senators and congressmen were sent a copy of an editorial on "Federalized Medicine," written by Meredith Nicholson and published in the *Indianapolis Star*. A copy of the editorial was also sent to our National Publicity Chairman, Mrs. William A. Goodson, Kansas City, Missouri.

In closing, may we ask for continued cooperation, and remember that the purpose of this committee is to serve *you*—each auxiliary, both large and small—in any way possible.

Historian

MRS. U. G. POLAND, *Chairman*

The history of the activities of the members of the Woman's Auxiliary to the Indiana State Medical Association shows these activities to be many and varied. It has been hard to give a complete report, for often the members, because of the many tasks to perform, have not been able to keep a detailed record. Many of the members are giving most of their time to Red Cross, hospital, and war activities.

It has not been easy to get reports directly from each Auxiliary, but the reports given at the state committee meeting show that the organizations have kept up their county programs, and have had

meetings to spread knowledge concerning the Wagner-Murray-Dingell Bill.

The new year should be one of more intense study of health education and post-war planning. The year ahead demands our best thought and alert thinking, and a new consecration of the work that must be done for the physicians at home and in the service.

A complete history of the state Auxiliary is about finished. Let me hear from every Auxiliary.

Public Relations

MRS. W. F. HUGHES, Chairman

The one important feature of the year's work was specifically to see that every woman in Indiana knew what the Wagner-Murray-Dingell Bill was and what it meant to the public if it should become a law. Each county organization did splendid work in this field. Many held special meetings to which the public was invited. Special national recognition was given to the large meeting held in Anderson at which eight hundred people assembled to hear Dr. Fishbein. Another large meeting was held in Kokomo with record attendance. Many of the labor groups had representatives at these meetings—and the people really seemed interested to learn more about the Wagner-Murray-Dingell Bill.

Meredith Nicholson, noted author and diplomat, wrote a paragraph in his special column of the *Indianapolis Star* against the bill. Copies of his article were mailed to the president of the American Medical Association; president of the Woman's National Auxiliary; and to the national chairman of Public Relations. Appreciative letters were received from each one.

The county auxiliaries did a part of each topic suggested in the programs advised.

Report of Highlights of Twenty-Second Meeting of House of Delegates of the Woman's Auxiliary to the American Medical Association

The following persons from Indiana were present at this meeting of the House of Delegates:

Mrs. A. W. Ratcliffe, Evansville, Chairman of Delegates

Mrs. Frank M. Gastineau, Indianapolis

Mrs. E. N. Mendenhall, Fort Wayne

Mrs. W. E. Tinney, Indianapolis

Mrs. C. E. Munk, Kendallville

Mrs. A. H. Duemling, Fort Wayne

Mrs. E. O. Nay, Terre Haute

National Board Member: Mrs. James W. Baxter, Jr., New Albany, Indiana.

Total Auxiliary membership this year: 24,356.

Total Auxiliary membership last year: 24,447.

Loss of ninety-one members.

Report of Nominating Committee, Mrs. R. E. Mosiman, chairman:

President-Elect: Mrs. Jesse D. Hamer, Phoenix, Arizona.

First Vice-President: Mrs. Eustace A. Allen, Atlanta, Georgia.

Second Vice-President: Mrs. J. Howard Hornberger, Roebling, New Jersey.

Third Vice-President: Mrs. Arnold H. Duemling, Fort Wayne, Indiana.

Fourth Vice-President: Mrs. David Berg, Helena, Montana.

Secretary: Mrs. A. A. Harold, Shreveport, Louisiana.

Treasurer: Mrs. Harold Wahlquist, Minneapolis, Minnesota.

Directors: Mrs. J. L. Stevens, Mansfield, Ohio; Mrs. Luther Kice, Hempstead, New York; Mrs. V. B. Philpot, Houston, Mississippi.

Indiana representation in national auxiliary activities: Mrs. Arnold H. Duemling, Regional Chairman in War Participation; Mrs. Ernest O. Nay, Regional Chairman in Organization; Mrs. James W. Baxter, Jr., member of Reading Committee, timekeeper at national convention; and Mrs. Duemling, a member of the Nominating Committee, and now a member of the national board.

ANNUAL REPORTS FROM COUNTY AUXILIARIES

ALLEN COUNTY

MRS. EMOR L. CARTWRIGHT, President

Number of members: 93. (Forty-six husbands are in the service at present. Thirty of their wives are with them. These members pay no dues but are carried on our roster.)

Meetings: Total number, 8. Average attendance, 50. Social, 3.

Educational, 5.

Legislation: Some at two meetings.

Public Relations:

(a) Three meetings for the laity and one radio address sponsored by the auxiliary. Dr. Austin E. Smith, of the American Medical Association, talked to the students of Concordia College and the International Business College, and to the members of the Lions Club. His radio talk was over station WOWO. Subject: "Drug Miracles in Modern Warfare."

(b) Christmas Seal Booth: 15 members, giving 109 hours, took charge of this.

(c) War Participation Activities: Doctors' Aides; USO; Recruiting Nurses, Wacs and Waves; 135 pounds of old jewelry collected and shipped; military news put in the doctors' monthly journal; and old magazines collected for shipment to servicemen in foreign countries.

(d) Civilian Defense: Sale of War Bonds; nutrition work; and Ration Board work.

(e) Red Cross:

1. Class graduates: First Aid, Ambulance Instruction, Staff Assistants and Nurses Aides.

2. Administration.

3. Blood Bank: All graduate nurses furnished by the Auxiliary; hostesses; blood donors; and short radio talk given by member for Blood Bank.

4. Navy Convoy.

5. Production: dressing, knitting, sewing, and supervision.

(f) Rummage Sale: receipts to be used for public relations.

Hygeia: Twenty-nine subscriptions.

Bulletin: Seven subscriptions.

Press and Publicity: Four hundred inches in two local newspapers; six flag heads and seven pictures.

CARROLL COUNTY

MRS. CHARLES WISE, President

Since we have only five members in our Auxiliary, we usually meet when our husbands have their medical meetings—these being dinner meetings. Carroll County is definitely a rural area, and since our transportation is somewhat curtailed we can not always work as a group, but we do work for the Auxiliary as individuals in each community. We assist our husbands with the extensive immunization program which is held at one of the community schools each year. We all assist with Red Cross activities, and gave approximately two hundred hours to sewing and knitting this year. We also sold War Bonds and Stamps. With the very great shortage of doctors in this county, our time is well spent trying to assist our husbands in any way that we can to save them time and effort.

CASS COUNTY

MRS. HARRY M. SHULTZ, President

The Cass County Auxiliary has seventeen members, and paid dues for five service wives. We have held eighteen meetings, meeting the third Friday of each month from September to May. Four meetings were held at the Cass County Hospital and four at the St. Joseph Hospital. We have devoted 1,355 hours to War Participation Activities by auxiliary members. We have had three educational, two legislative, and one social meeting this year.

CLARK COUNTY

MRS. R. G. BURMAN, President

The Clark County Medical Auxiliary was organized January 24, 1944. On February seventh a social and business meeting was held, and the president appointed the various committee members. Another meeting was held on March sixth at which time a report on the Wagner-Murray-Dingell Bill was given, and there was a speaker in connection with the Cancer Control drive. The Auxiliary has met three other times, and sewed for the hospital. Seeds, flowers, bulbs and shrubs were donated to beautify the hospital grounds.

DELAWARE-BLACKFORD COUNTIES

MRS. U. G. POLAND, President

This organization has thirty-four active members and sixteen members whose husbands are in the Army. We have six honorary members who are, because of age or other conditions, kept on the honor roll because of former service.

Most of the wives of service men are unable to help in war work, because of children who must have their attention, and other hindrances. Seven have left the city and may not return. Only two are able to come once in a while.

A part of the past year we had a hospital or Red Cross meeting, working for the organizations. We had alter-

nating meetings of work and regular meetings for social and educational study. The last part of the year we have been meeting every two months, omitting work at the Red Cross and hospital.

We have stressed the study of the Wagner-Murray-Dingell Bill. Dr. Montgomery, one of our physicians, a representative of the medical society, addressed one of our meetings. We had invited guests. It was a splendid, well-attended meeting. Dr. Montgomery has spoken to service clubs and women's organizations. We feel that he has reached many with his message. He is a splendid, well-prepared speaker. A member of our auxiliary and a Y.W.C.A. board member suggested an open forum on the bill at the Y.W.C.A. This was well publicized in the press and an audience of two hundred was present to hear the discussion. The report of the press was quite thorough. The speakers were: Dr. Loren E. Kerr, Oberlin, Ohio, and Dr. F. S. Crockett, Lafayette.

The members of the auxiliary have been most helpful in the organization, and while all are overburdened with other activities they are determined to hold together and be ready for any emergency that may occur.

One of our members is a busy practicing physician; one, the wife of a physician and a registered nurse is employed in a doctor's office; one is superintendent of the Ball Hospital; one is employed in the Department of Public Welfare and works on an average of thirty-eight and one-half hours a week; one is a member of the Board of Public Welfare; one is on the Board of the Tuberculosis Association, and one is on the Board of the Visiting Nurses Association. Many of our members serve actively in many of the other women's organizations of the town.

Ten dollars was given for literature for the nurses at the hospital.

Twenty-eight hundred and twenty-five hours were spent in auxiliary activities.

ELKHART COUNTY

MRS. A. C. YODER, President

We had four meetings during the year, having them when our husbands did in order to conserve gas. Our meetings were all held in Elkhart, ten miles from Goshen, except the last one which was held in Goshen. We had one joint meeting with our husbands which was very nice, with a fine speaker. Our meetings were all dinner meetings. At one we had a book review, one was a social affair, and the others were just business meetings. Our members all assisted with Red Cross work, and the number of hours spent in various activities ran into the thousands.

Our new president is Mrs. Floyd Freeman, of Goshen.

FLOYD COUNTY

MRS. SAMUEL M. BAXTER, President

The Woman's Auxiliary to the Floyd County Medical Society is especially honored and pleased this year to have one of its own members, Mrs. James W. Baxter, Jr., as president of the Woman's Auxiliary to the Indiana State Medical Association.

Mrs. Baxter has visited many county auxiliaries during the year and has been very helpful and inspirational with their work. She takes part in local club activities and gives much time to the Staff Assistance Training Course of the Red Cross, and is also chairman of the Home Service Department.

There are twenty-eight members in the Floyd County Auxiliary, and many of their husbands are in the service. During the past year these women have given much time to the following branches of Red Cross work; Staff Assistance, Blood Bank, Home Nursing, Nurses Aides, Surgical Dressings, and Knitting. They have also helped with the sale of United States War Bonds and Stamps.

Luncheon meetings were held each month after which informative papers were given, and occasionally we had a guest speaker on our program.

The auxiliary donated six *Hygeia* subscriptions to the schools and public library. The members also assisted with the County Immunization Program, which is conducted annually by the Floyd County Medical Society and the Third District Health Department.

Our annual public relations meeting was to have been a tea, April 12, at the Masonic Temple. Mr. Clarence A. Jackson, vice-president of the Indiana State Chamber of Commerce, was to be the speaker for the occasion. His engagement was cancelled, however, because of a special called session of the Indiana Legislature. This meeting has been postponed until a later date.

HOWARD COUNTY

MRS. G. N. DRULEY, President

The Woman's Auxiliary to the Howard County Medical Society was organized February 22, 1940. There is now a membership of thirty. We have lost five members whose husbands are in the armed forces.

Eight educational and social meetings were held during the year, with an average attendance of sixteen. One meeting was entirely social. Seven were educational, with a social period. At two meetings round table discussions were held by members on "The Wagner-Murray-Dingell Bill." At one meeting the legislative chairman presented material from *The Journal of the American Medical Association*. One meeting was given over to the *Hygeia* and *Bulletin* chairmen.

The public relations meeting was a tea to which representative club women of the city were invited. One hundred and fifty guests were present. Mrs. Eva K. Packard was the guest speaker, explaining the Wagner-Murray-Dingell Bill.

The most important meeting of the year was an open meeting in the Memorial Hall of the County Court House, with Dr. Morris Fishbein as guest speaker, who addressed an audience of more than five hundred. Among the organizations represented were the A. F. of L., CIO, County Dental Society, chairmen of the Republican and Democratic parties, and many others. Four of our members work two to eight hours a day in their husband's offices. Two are part-time helpers.

Our War Participation hours have not yet been counted.

We want to study "post-war planning" next year.

LAKE COUNTY

MRS. J. W. MATHER, President

The Lake County Medical Auxiliary has felt that they could arrange public meetings at which the Lake County Medical Society could present their views on the Wagner-Murray-Dingell Bill on "Socialized Medicine." A meeting to acquaint the county auxiliary members was held in Gary in January at which more than one hundred doctors' wives were present.

A public meeting was held in East Chicago in the University Extension Building in April, at which Dr. N. K. Forster, president-elect of the Indiana State Medical Association, spoke. About five hundred invitations had been mailed to labor groups, American Legion posts, Parent-Teacher groups, sororities, the League of Women Voters, political groups, and leaders. Representatives from many of these groups came, and a lively discussion period followed Dr. Forster's talk.

A larger meeting is being planned for Gary in the fall when National party attitudes are better known.

In June the members of the county auxiliary plan their

annual June luncheon at the Woodmar Country Club, and plan to attend the national convention in a group.

The Gary branch meets once a month and has had several educational meetings on the Red Cross, Tuberculosis Association, Wagner-Murray-Dingell Bill, and service for the hospitals and nurses in service. All meetings were well attended.

The Hammond branch plans to start regular meetings in the fall, and work for the equipment of the hospitals. They had a very interesting meeting this spring, to plan their year ahead. The East Chicago branch has not been holding regular meetings, but have had several members active in the county work.

In the fall the county auxiliary will meet at a luncheon to plan and get the year's work under way.

LAPORTE COUNTY

MRS. LOUIS MOOSEY, President

The Woman's Auxiliary to the LaPorte County Medical Society has not been very active during the past year, but it did have one meeting every three months. The meetings were all of a social nature, and the average attendance was fifteen. The Wagner-Murray-Dingell Bill was discussed at one meeting, and members signed a letter protesting it. This was sent to Congressman Grant.

MADISON COUNTY

MRS. A. W. ELSTEN, President

The Madison County Auxiliary has a membership of twenty-five, and held nine meetings this year, with an average attendance of twelve. All members have given pertinent facts concerning the Wagner-Murray-Dingell Bill before their clubs and organizations. Members have devoted time to various Red Cross work; teaching of first aid and home nursing; motor corps; dressings, and blood donations. The auxiliary has served for the St. Johns Hospital and helped with the pledge to the new wing of the hospital.

Parent-Teacher organizations have been approached as to furnishing speakers for their programs; the topic to be the "Wagner-Murray-Dingell Bill." The Board of directors of the local Y.W.C.A. have been asked their views and opinions of the bill, and if they are endorsing the national policy of the Y.W.C.A.

On October 18, 1943, the auxiliary sponsored a joint dinner meeting of the county society and the county auxiliary. Mr. Hendricks was the guest speaker, his subject being the "Wagner-Murray-Dingell Bill." Dr. McCaskey was also a guest.

On May twenty-ninth we sponsored a public address in the evening, by Dr. Morris Fishbein, on the subject of "Socialized Medicine." At noon he spoke to all the service clubs of Anderson. Invitations were mailed to every club and organization in the county. Doctors and their wives from surrounding counties were invited to the meeting.

MARION COUNTY

MRS. G. W. GUSTAFSON, President

The Woman's Auxiliary to the Marion County Medical Society has 162 paid-up members. Four meetings were held during the year. The first meeting was a tea held at the Governor's Mansion, honoring the wives of physicians in service. Guests at this meeting included the wives of doctors from Camp Atterbury, Fort Benjamin Harrison, Bilings Hospital, and Stout Field.

The second meeting of the year was the annual Public Relations meeting, which was held in the auditorium of L. S. Ayres & Co. Representatives of various women's organizations throughout the city were invited to this meeting. Lieutenant Bill J. Barkley, psychologist, of Billings General Hospital, spoke on "War Neuroses." Tea was served following the program.

An evening party was given by the auxiliary for their husbands and families at the Methodist Hospital Nurses' Home. Home talent among the doctors' children was the highlight of the evening.

The last meeting consisted of the election of officers for the coming year, and a program of "Riley" given by E. O. Snethen, Indianapolis attorney, was very much enjoyed by all. A gift of one hundred dollars was voted by the auxiliary to be given to the Flower Mission. This money is to be applied to furnishing of the auditorium which is under construction.

MARSHALL COUNTY

MRS. HOMER BURK, *President*

Four meetings were held during the year of 1943-1944 by the Woman's Auxiliary to the Marshall County Medical Society. The average attendance at these meetings was five. The programs were all of a social nature. Our members are few, but we do enjoy our meetings even though we can not do very much at present. We have not been able to have any definite projects, but all of our members do take part in Red Cross work.

NORTHEASTERN INDIANA ACADEMY OF MEDICINE

MRS. C. E. MUNK, *President*

The Woman's Auxiliary to the Northeastern Indiana Academy of Medicine has a membership of twenty-three. Three of these have husbands in the armed forces.

One meeting was held this year for the purpose of election of officers and instruction of members in the objectives of the auxiliary. Since it is not possible to hold regular meetings, our members were urged to work for the auxiliary as individuals.

Four students were pledged for the United States Cadet Nurse Corps. Three talks on "Socialized Medicine," and three talks on "Military Medicine" were given by our members. Members were active in Red Cross work; Nutrition; Home Nursing; Blood Donor and Health Service Committees, and two are teaching "Home Nursing," and two "Nutrition."

Under Civilian Defense, one member is medical director and some have served on the Ration Boards. One member is chairman of a Victory Aid Committee, two are Girl Scout leaders, three are Sunday School teachers, and one has returned to school teaching in furtherance of the war effort.

Volunteer service totals 575 hours, not including the time given by committee chairmen.

The *Bulletin* and *Hygeia* have one subscriber each.

PORTER COUNTY

MRS. E. H. MILLER, *President*

Number of members: fourteen. Number of members whose husbands are in service: four. Number of meetings held from September, 1943, to May, 1944: eight. Average attendance: six.

Nature of meetings: Educational and Legislative. The meetings are held on the same evening as the medical

society meeting, that is, the last Tuesday in the month. The auxiliary meets separately. Each meeting is preceded by a dinner, usually at a hotel. Topics are discussed by members of the auxiliary. Last year our historian gave the history of one of our pioneer physicians, and this year the historian added to that the history of another pioneer physician.

Activities of auxiliary members as individuals: One member is chairman of the Cancer Control drive, another is a member of the City Board of Education, another is State Director of all Junior Relief Corps and does secretarial work at the hospital. Three members are full-time doctors' aides. One member is on the Ration Board.

ST. JOSEPH COUNTY

MRS. M. J. THORNTON, *President*

The Woman's Auxiliary to the St. Joseph County Medical Society has a membership of forty. The group had six meetings throughout the year, one of which was held in the evening. They met in the homes of the various members. The final meeting was a Spring guest tea. In January an outside speaker talked on "School Truancy," and in March there was a book review. Following the business at these meetings the remainder of the time was spent socially, and dessert was served. The year's projects have been as follows: Editing the *Bulletin* for the Medical Society, to be sent to the service doctors and all doctors still at home. A *Bulletin* also is sent to each nurse in the service. *Hygeia* was again a project, and the Auxiliary placed the magazine in the schools of South Bend and Mishawaka, and in the county high school. Jewelry was collected for the state "barrel," for the men in the Pacific. Two T.B. bonds were purchased, and fifteen dollars was sent to the Red Cross.

TIPPECANOE COUNTY

MRS. GEORGE R. DONAHUE, *President*

The Woman's Auxiliary to the Tippecanoe Medical Society has retained an active organization during the past year, but has found it impossible to hold the usual number of meetings.

There are twenty-five members, and four dinner meetings were held at the Lafayette Country Club with an average attendance of fifteen. Too little gasoline and too many young war wives at home on leave in other towns cut down our membership. This we hope is a temporary condition, and that we can soon build up our number and interest "when the lights come on again all over the world." Many of our members have taken an active part in Red Cross work, and the support of our schools and hospitals, and in producing food on farms owned by them.

A program of some kind has been given at each meeting. The subject of "socialized medicine" was turned upside down and inside out, and the whole idea thrown out the window. Medical news was given each time we met, and topics of general interest to hospitals and the profession were studied.

VANDEBURGH COUNTY

MRS. A. W. RATCLIFFE, *President*

The following programs were given this year by the Vanderburgh County Auxiliary:

October—Luncheon: Outline of the Wagner-Murray-Dingell Bill, by Mrs. William Healy. "A Resume of the Public Health Service," by Dr. Fletcher Stewart.

November—Luncheon: "Problems in Juvenile Delinquency," by Mr. Lowell Turner and Mr. Maurice Hunt.

January—Executive Board luncheon and tea, for all members, at Mrs. Mell B. Welborn's home, for State Auxiliary President, Mrs. James W. Baxter, Jr., and the State Corresponding Secretary, Mrs. John F. Habermel.

March—Luncheon: Adoption of revised Constitution and By-laws. "Wartime Food Problems in the Hospital," by Miss Corine Catlin, Dietitian.

May (Annual Meeting): Covered dish luncheon and bridge at Mrs. A. W. Ratcliffe's home. Reports of officers and committees. Installation of officers for 1944-45.

The projects for 1943-44 were: (1) offered services to the medical society to help combat Wagner-Murray-Dingell Bill; (2) fluorescent lights given to Hillcrest Home for both boys' and girls' study rooms; (3) resolution sent to proper authorities, offering aid in the solution of the juvenile delinquency problem; (4) participation in the sale of Christmas Seals for the Tuberculosis Association; (5) revision and adoption of Constitution and By-laws; and (6) membership raised to sixty-four, largest roster in the history of the organization and the third largest in the state for 1944.

VIGO COUNTY

MRS. M. B. VAN CLEAVE, President

The Vigo County Auxiliary is seventeen years old. Our low membership is due to many of our doctors and their wives being away in the armed forces. Average attendance has been forty.

We have had six meetings, varied in nature, such as picnic luncheons followed by business meetings and sewing for Red Cross; annual banquet with a guest speaker; legislative and public relations meeting, with Dr. Morris Fishbein as speaker on the "Wagner-Murray-Dingell Bill," at which there was an overflow crowd at the Sycamore Theatre. This was the highlight of the year, there being dozens of organizations represented.

There was a dinner meeting preceding the lecture at which time we had the honor of entertaining our State

President, Mrs. James W. Baxter, Jr. Her message to us was most educational and inspiring.

The last meeting was a dinner followed by annual reports, which showed splendid service as per our report on war activities, et cetera.

Through the gift of money from our County Medical Society for subscriptions to *Hygeia*, we have been able to widen its scope of usefulness and place it in many public places.

We are proud to be the sponsors of "occupational therapy" in both city hospitals. With the aid of a civic club, we are able to employ an instructor four days a week at the hospitals and one day a week at their outpatient work shop down town. The success of this project is largely due to the interest of our physicians.

THE WOMAN'S MEDICAL AUXILIARY COLLECT

We ask Thee, O God of Heaven and Earth, to keep us, we the helpmates of those whose life work is the ministry of healing.

May we learn to know that their sacrifice is not small, but motivates their lives in service to others. Help us to have unselfish, understanding hearts.

Keep us patient and forbearing, and as it is given us to keep the hearth of our home fires swept clean of pettiness, so give us strength to be kind and generous in thought at all times.

Mrs. H. A. Ray

HOUSE OF DELEGATES, INDIANA STATE MEDICAL ASSOCIATION

Indianapolis, October 3, 4, and 5, 1944

<i>Delegates</i>	<i>Alternates</i>	<i>Delegates</i>	<i>Alternates</i>
	ADAMS		DEARBORN-OHIO
Gerald J. Kohne, Decatur	R. G. Zimmerman, Berne	O. H. Stewart, Aurora	
	ALLEN	G. S. Fessler, Rising Sun	
William Wright, Fort Wayne	L. S. McKeeman, Fort Wayne		DECATUR
M. R. Lohman, Fort Wayne	E. R. Carlo, Fort Wayne	I. M. Sanders, Greensburg	H. S. McKee, Greensburg
M. B. Catlett, Fort Wayne			DEKALB
	BARTHOLOMEW		DELAWARE-BLACKFORD
Joseph E. Dudding, Hope	H. H. Kamman, Columbus	L. G. Montgomery, Muncie	Elmer T. Cure, Muncie
V. L. Turley, Fowler	BENTON	Clay A. Bail, Muncie	T. R. Owens, Muncie
	Virgil Scheurich, Oxford		
R. J. Harvey, Zionsville	BOONE		DUBOIS
	William H. Spieth, Lebanon	Paul J. Blessinger, Jasper	Henry G. Backer, Ferdinand
Max R. Adams, Flora	CARROLL		ELKHART
	C. L. Wise, Camden	A. C. Yoder, Goshen	S. T. Miller, Elkhart
B. W. Egan, Logansport	CASS		FAYETTE-FRANKLIN
	D. E. Lybrook, Young America	L. N. Ashworth, Connersville	H. C. Metcalf, Connersville
E. P. Buckley, Jeffersonville	CLARK	E. M. Glaser, Brookville	H. N. Smith, Brookville
	D. L. Carlberg, Jeffersonville		FLOYD
	CLAY	G. Irene Polhemus, New Albany	C. E. Briscoe, New Albany
Fred C. Dilley, Brazil	J. F. Maurer, Brazil		FOUNTAIN-WARREN
	CLINTON	J. Carl Freed, Attica	
	CRAWFORD		FULTON
J. J. Johnson, Milltown	Jesse Benz, Marengo	A. E. Stinson, Rochester	
	DAVIESS-MARTIN		

<i>Delegates</i>	<i>Alternates</i>	<i>Delegates</i>	<i>Alternates</i>
GIBSON		MONTGOMERY	
Carl Clark, Oakland City	O. T. Brazelton, Princeton	T. Z. Ball, Crawfordsville	G. A. Collett, Crawfordsville
GRANT		MORGAN	
L. D. Holliday, Fairmount	R. W. Lavengood, Marion	NOBLE	
GREENE		A. L. Fipp, Rome City	C. E. Munk, Kendallville
K. L. Hull, Bloomfield	H. B. Turner, Bloomfield	ORANGE	
HAMILTON		C. E. Boyd, West Baden Springs	John K. Spears, Paoli
C. M. Donahue, Carmel	R. F. Harris, Noblesville	OWEN	
HANCOCK		PARKE-VERMILLION	
Jesse E. Ferrell, Fortville	Hugh K. Navin, Fortville	PERRY	
HARRISON		N. A. James, Tell City	P. J. Coultas, Tell City
William E. Amy, Corydon		PIKE	
HENDRICKS		J. T. Kime, Petersburg	D. W. Bell, Otwell
O. T. Scamahorn, Pittsboro	C. B. Thomas, Plainfield	PORTER	
HENRY		John R. Frank, Valparaiso	John F. Take, Valparaiso
W. U. Kennedy, New Castle	W. A. Miller, Hagerstown	POSEY	
HOWARD		PULASKI	
E. R. Clarke, Kokomo	H. M. Rhorer, Kokomo	PUTNAM	
HUNTINGTON		V. Earle Wiseman, Greencastle	G. F. Parker, Greencastle
G. M. Nie, Huntington	H. S. Brubaker, Huntington	RANDOLPH	
JACKSON		W. S. Dininger, Winchester	R. B. Engle, Farmland
L. H. Osterman, Seymour	L. W. Elsner, Seymour	RIPLEY	
JASPER-NEWTON		R. Lee Smith, Osgood	John C. Bigham, Batesville
Harry English, Rensselaer	M. D. Gwin, Rensselaer	RUSH	
R. H. Ruhmkorff, Goodland	W. G. Pippenger, Brook	C. C. Atkins, Rushville	L. M. Green, Rushville
JAY		ST. JOSEPH	
G. V. Cring, Portland		A. S. Giordano, South Bend	J. E. McMeel, South Bend
JEFFERSON		Morris Balla, South Bend	J. V. Cassady, South Bend
JENNINGS		F. R. N. Carter, South Bend	D. W. Frash, South Bend
D. W. Matthews, North Vernon	J. H. Green, North Vernon	SCOTT	
JOHNSON		SHELBY	
Oran A. Province, Franklin	Walter Portteus, Franklin	W. D. Inlow, Shelbyville	P. R. Tindall, Shelbyville
KNOX		SPENCER	
KOSCIUSKO		John H. Barrow, Dale	C. L. Springstun, Chrisney
LAGRANGE		STARKE	
W. O. Hildebrand, Topeka	Harry Erwin, Lagrange	STEUBEN	
LAKE		W. H. Lane, Angola	B. A. Blosser, Fremont
G. L. Verplank, Gary	F. J. McMichael, Gary	SULLIVAN	
P. Q. Row, Hammond	C. C. Brink, Gary	J. R. Crowder, Sullivan	C. E. Whipps, Carlisle
H. W. Eggers, Hammond	J. S. Niblick, East Chicago	SWITZERLAND	
C. R. Pettibone, Crown Point	D. F. McGuire, East Chicago	L. H. Bear, Vevay	Fred C. Bakes, Vevay
C. M. Jones, Whiting	R. M. Hedrick, Gary	TIPPECANOE	
LAPORTE		Earl Van Reed, Lafayette	R. R. Calbert, Lafayette (in service)
Jon Kelly, LaPorte	Robert W. Kepler, LaPorte	Gordon A. Thomas, Lafayette	O. L. McCay, Romney
LAWRENCE		TIPTON	
Claude Dollens, Oolitic	John R. Pearson, Bedford	S. M. Cotton, Goldsmith	A. E. Stouder, Kempton
MADISON		VANDERBURGH	
A. W. Elsten, Anderson	A. T. Jones, Pendleton	VIGO	
C. S. Wright, Anderson	W. D. Hart, Anderson	E. O. Nay, Terre Haute	W. C. Kunkler, Terre Haute
MARION		M. C. Topping, Terre Haute	A. W. Cavins, Terre Haute
George J. Garceau, Indianapolis	Kenneth L. Craft, Indianapolis	WABASH	
Ben B. Moore, Indianapolis	Earl B. Rinker, Indianapolis	O. G. Brubaker, North Manchester	F. M. Whisler, Wabash
Roy V. Myers, Indianapolis	John E. Dalton, Indianapolis	WARRICK	
Goethe Link, Indianapolis	Glenn C. Lord, Indianapolis	WASHINGTON	
O. H. Bakemeier, Indianapolis	Frank L. Jennings, Indianapolis	Claude B. Paynter, Salem	William Green, Pekin
William N. Wishard, Jr., Indianapolis	A. H. Harold, Indianapolis	WAYNE-UNION	
Harold Ochsner, Indianapolis	J. N. Collins, Indianapolis	H. P. Ross, Richmond	E. E. Holland, Richmond
Russell Sage, Indianapolis	James H. Stygall, Indianapolis	W. A. Thompson, Liberty	W. B. McWilliams, Liberty
Ernest Rupel, Indianapolis	Clifford Jinks, Indianapolis	WELLS	
Rollin Moser, Indianapolis	R. E. Mitchell, Indianapolis	Robert Wybourn, Ossian	H. Brooks Smith, Bluffton
Walter Morton, Indianapolis	Robert Masters, Indianapolis	WHITE	
J. O. Ritchey, Indianapolis	Paul Merrell, Indianapolis	H. B. Gable, Monticello	J. P. Galbreth, Burnettsville
Marlow Manion, Indianapolis	D. A. Bartley, Indianapolis	WHITLEY	
MARSHALL		Paul A. Garber, South Whitley	Park Huffman, South Whitley
A. A. Thompson, Tyner	T. R. Possolt, Plymouth		
MIAMI			
F. M. Lynn, Peru	E. Lee Burrous, Peru		
MONROE			
Naomi Dalton, Bloomington	H. S. Hepner, Bloomington		

LIST OF PRESIDENTS OF THE INDIANA
STATE MEDICAL ASSOCIATION
SINCE ITS ORGANIZATION

<i>Name and Residence</i>	<i>Elected</i>	<i>Served</i>
*Livingston Dunlap, Indianapolis.....	1849	1849
*William T. S. Cornett, Versailles.....	1849	1850
*Ashahel Clapp, New Albany.....	1850	1851
*George W. Mears, Indianapolis.....	1851	1852
*Jeremiah H. Brower, Lawrenceburg.....	1852	1853
*Elizur H. Deming, Lafayette.....	1853	1854
*Madison J. Bray, Evansville.....	1854	1855
*William Lomax, Marion.....	1855	1856
*Daniel Meeker, LaPorte.....	1856	1857
*Talbot Bullard, Indianapolis.....	1857	1858
*Nathan Johnson, Cambridge City.....	1858	1859
*David Hutchinson, Mooresville.....	1859	1860
*Benjamin S. Woodworth, Fort Wayne.....	1860	1861
*Theophilus Parvin, Indianapolis.....	1861	1862
*James F. Hibbard, Richmond.....	1862	1863
*John Sloan, New Albany.....	1863	1864
*John Moffett (acting), Rushville.....	1864	1864
*Samuel M. Linton, Columbus.....	1864	1865
*Wilson Lockhart (acting), Danville.....	1865	1865
*Myron H. Harding, Lawrenceburg.....	1865	1866
*Vierling Kersey, Richmond.....	1866	1867
*John S. Bobbs, Indianapolis.....	1867	1868
*Nathaniel Field, Jeffersonville.....	1868	1869
*George Sutton, Aurora.....	1869	1870
*Robert M. Todd, Indianapolis.....	1870	1871
*Henry P. Ayres, Fort Wayne.....	1871	1872
*Joel Pennington, Milton.....	1872	1873
*Isaac Casselberry, Evansville.....	1873	.....
*Wilson Hobbs, Knightstown.....	1873	1874
*Richard E. Haughton, Richmond.....	1874	1875
*John H. Helm, Peru.....	1875	1876
*Samuel S. Boyd, Dublin.....	1876	1877
*Luther D. Waterman, Indianapolis.....	1877	1878
*Louis Humphreys, South Bend.....	1878	.....
*Benj. Newland (acting), Bedford (v.-p.).....	1878	1879
*Jacob R. Weist, Richmond.....	1879	1880
*Thomas B. Harvey, Indianapolis.....	1880	1881
*Marshall Sexton, Rushville.....	1881	1882
*William H. Bell, Logansport.....	1882	1883
*Samuel E. Munford, Princeton.....	1883	1884
*James H. Woodburn, Indianapolis.....	1884	1885
*James S. Gregg, Fort Wayne.....	1885	1886
*General W. H. Kemper, Muncie.....	1886	1887
*Samuel H. Charlton, Seymour.....	1887	1888
*William N. Wishard, Indianapolis.....	1888	1889
*James D. Gatch, Lawrenceburg.....	1889	1890
*Gonsolvo C. Smythe, Greencastle.....	1890	1891
*Edwin Walker, Evansville.....	1891	1892
*George F. Beasley, Lafayette.....	1892	1893
*Charles A. Daugherty, South Bend.....	1893	1894
*Elijah S. Elder, Indianapolis.....	1894	.....
Charles S. Bond (acting), Richmond.....	1894	1895
*Miles F. Porter, Fort Wayne.....	1895	1896
*James H. Ford, Wabash.....	1896	1897
*William N. Wishard, Indianapolis.....	1897	1898
*John C. Sexton, Rushville.....	1898	1899
*Walker Schell, Terre Haute.....	1899	1900
*George W. McCaskey, Fort Wayne.....	1900	1901
*Alambert W. Brayton, Indianapolis.....	1901	1902
*John B. Berteling, South Bend.....	1902	1903
*Jonas Stewart, Anderson.....	1903	1904
*George T. MacCoy, Columbus.....	1904	1905
*George H. Grant, Richmond.....	1905	1906
*George J. Cook, Indianapolis.....	1906	1907
*David C. Peyton, Jeffersonville.....	1907	1908
*George D. Kahlo, French Lick.....	1908	1909
*Thomas C. Kennedy, Shelbyville.....	1909	1910
*Frederic C. Heath, Indianapolis.....	1910	1911
*William F. Howat, Hammond.....	1911	1912
*A. C. Kimberlin, Indianapolis.....	1912	1913

* Deceased.

<i>Name and Residence</i>	<i>Elected</i>	<i>Served</i>
*John P. Salb, Jasper.....	1913	1914
*Frank B. Wynn, Indianapolis.....	1914	1915
*George F. Keiper, Lafayette.....	1915	1916
*John H. Oliver, Indianapolis.....	1916	1917
*Joseph Rilus Eastman, Indianapolis.....	1917	1918
William H. Stemm, North Vernon.....	1918	1919
*Charles H. McCully, Logansport.....	1919	1920
*David Ross, Indianapolis.....	1920	1921
William R. Davidson, Evansville.....	1921	1922
*Charles H. Good, Huntington.....	1922	1923
*Samuel E. Earp, Indianapolis.....	1923	1924
E. M. Shanklin, Hammond.....	1924	1925
Charles N. Combs, Terre Haute.....	1925	1926
*Frank W. Cregor, Indianapolis.....	1926	1927
George R. Daniels, Marion.....	1926	1928
Charles E. Gillespie, Seymour.....	1927	1929
*Angus C. McDonald, Warsaw.....	1928	1930
Alois B. Graham, Indianapolis.....	1929	1931
Franklin Smith Crockett, Lafayette.....	1930	1932
Joseph H. Weinstein, Terre Haute.....	1931	1933
Everett E. Padgett, Indianapolis.....	1932	1934
*Walter J. Leach, New Albany.....	1933	1935
Roscoe L. Sensenich, South Bend.....	1934	1936
*Edmund Dougan Clark, Indianapolis.....	1935	1937
Herman M. Baker, Evansville.....	1936	1938
Edmund M. Van Buskirk, Fort Wayne.....	1937	1939
Karl R. Ruddell, Indianapolis.....	1938	1940
Albert M. Mitchell, Terre Haute.....	1939	1941
M. A. Austin, Anderson.....	1940	1942
C. H. McCaskey, Indianapolis.....	1941	1943
J. T. Oliphant, Farmersburg.....	1943	1944

* Deceased.

DATA FROM PREVIOUS SESSIONS

<i>Year</i>	<i>Session</i>	<i>Place</i>	<i>Registration</i>
1908	59th	French Lick	312
1909	60th	Terre Haute	421
1910	61st	Fort Wayne	450
1911	62nd	Indianapolis	748
1912	63rd	Indianapolis	590
1913	64th	West Baden	312
1914	65th	Lafayette	527
1915	66th	Indianapolis	646
1916	67th	Fort Wayne	381
1917	68th	Evansville	270
1918	69th	Indianapolis	388
1919	70th	Indianapolis	.....
1920	71st	South Bend	421
1921	72nd	Indianapolis	550
1922	73rd	Muncie	522
1923	74th	Terre Haute	823
1924	75th	Indianapolis	1,012
1925	76th	Marion	800
1926	77th	West Baden	900
1927	78th	Indianapolis	1,500
1928	79th	Gary	892
1929	80th	Evansville	814
1930	81st	Fort Wayne	1,115
1931	82nd	Indianapolis	1,033
1932	83rd	Michigan City	904
1933	84th	French Lick	637
1934	85th	Indianapolis	1,814
1935	86th	Gary	1,011
1936	87th	South Bend	1,150
1937	88th	French Lick	1,154
1938	89th	Indianapolis	1,751
1939	90th	Fort Wayne	1,332
1940	91st	French Lick	1,064
1941	92nd	Indianapolis	1,890
1942	93rd	French Lick	706
1943	94th	Indianapolis	1,323
1944	95th	Indianapolis	(?)

REFERENCE COMMITTEES — 1944

1. SECTIONS AND SECTION WORK:

Chairman, L. G. Montgomery, Muncie (Delaware)
 O. G. Brubaker, North Manchester (Wabash)
 Morris Balla, South Bend (St. Joseph)
 V. L. Turley, Fowler (Benton)
 O. H. Stewart, Aurora (Dearborn)

2. RULES AND ORDER OF BUSINESS:

Chairman, Charles N. Combs, Terre Haute (Vigo)
 Earl Van Reed, Lafayette (Tippecanoe)
 W. U. Kennedy, New Castle (Henry)
 Carl Clark, Oakland City (Gibson)
 Fred C. Dilley, Brazil (Clay)

3. MEDICAL EDUCATION AND HOSPITALS:

Chairman, Ernest Rupel, Indianapolis (Marion)
 G. V. Cring, Portland (Jay)
 Gordon A. Thomas, Lafayette (Tippecanoe)
 Harold Ochsner, Indianapolis (Marion)
 E. P. Buckley, Jeffersonville (Clark)

4. PUBLIC POLICY AND LEGISLATION:

Chairman, Jesse E. Ferrell, Fortville (Hancock)
 A. A. Thompson, Tyner (Marshall)
 J. O. Ritchey, Indianapolis (Marion)
 Alfred Ellison, South Bend (St. Joseph)
 H. W. Eggers, Hammond (Lake)

5. PUBLICITY:

Chairman, Rollin Moser, Indianapolis (Marion)
 John H. Barrow, Dale (Spencer)
 F. R. N. Carter, South Bend (St. Joseph)
 Paul A. Garber, South Whitley (Whitley)
 Jon Kelly, LaPorte (LaPorte)

6. HYGIENE AND PUBLIC HEALTH:

Chairman, Goethe Link, Indianapolis (Marion)
 C. C. Atkins, Rushville (Rush)
 W. D. Inlow, Shelbyville (Shelby)
 W. H. Lane, Angola (Steuben)
 P. Q. Row, Hammond (Lake)

7. AMENDMENTS TO CONSTITUTION AND BY-LAWS:

Chairman, George Daniels, Marion (Grant)
 W. C. Wright, Fort Wayne (Allen)
 B. W. Egan, Logansport (Cass)
 I. M. Sanders, Greensburg (Decatur)
 F. M. Lynn, Peru (Miami)

8. REPORTS OF OFFICERS:

Chairman, C. S. Black, Warren (Huntington)
 Clay Ball, Muncie (Delaware)
 George J. Garceau, Indianapolis (Marion)
 E. O. Nay, Terre Haute (Vigo)
 J. R. Crowder, Sullivan (Sullivan)

9. COMMITTEE ON CREDENTIALS:

Chairman, S. M. Cotton, Goldsmith (Tipton)
 A. E. Stinson, Rochester (Fulton)
 Ralph J. Harvey, Zionsville (Boone)
 Max R. Adams, Flora (Carroll)
 G. S. Fessler, Rising Sun (Ohio)

10. COMMITTEE ON MISCELLANEOUS BUSINESS:

Chairman, M. C. Topping, Terre Haute (Vigo)
 J. C. Elliott, Guilford (Dearborn)
 N. A. James, Tell City (Perry)
 Paul J. Blessinger, Jasper (Dubois)
 M. R. Lohman, Fort Wayne (Allen)

11. SPECIAL COMMITTEE ON STATE BOARD OF HEALTH PROGRAM:

Chairman, Harry P. Ross, Richmond (Wayne)
 E. R. Clarke, Kokomo (Howard)
 C. M. Donahue, Carmel (Hamilton)
 Naomi Dalton, Bloomington (Monroe)
 W. A. Thompson, Liberty (Union)

Exhibitors

Booth Number

- 1 —BILHUBER-KNOLL CORPORATION, Orange, N.J.
- 2 —GENERAL ELECTRIC X-RAY CORPORATION, Chicago, Ill.
- 3 —DUREX PRODUCTS, INC., New York, N.Y.
- 4 —ZIMMER MANUFACTURING COMPANY, Warsaw, Ind.
- 5-6 —SCHENLEY LABORATORIES, INC., Lawrenceburg, Ind., and New York City.
- 7 —GRUNE & STRATTON, INC., New York, N.Y.
- 8 —SHARP AND DOHME, INC., Philadelphia, Pa.
- 9 —SCIENTIFIC SUGARS COMPANY, Columbus, Ind.
- 16 —BLUE CROSS HOSPITAL SERVICE, MUTUAL HOSPITAL INSURANCE, INC., Indianapolis, Ind.
- 17 —DAIRY COUNCILS OF INDIANA.
- 18 —AMES COMPANY, INC., Elkhart, Ind.
- 19 —THE MAX WOCHER & SON COMPANY, Cincinnati, Ohio.
- 20 —ORTHO PRODUCTS, INC., Linden, N.J.
- 21 —SCHERING CORPORATION, Bloomfield, N.J.
- 22 —C. B. FLEET COMPANY, INC., Lynchburg, Va.
- 23 —PHILIP MORRIS & COMPANY, LTD., INC., New York, N.Y.

Booth Number

- 24 —PARKE, DAVIS AND COMPANY, Detroit, Mich.
- 25 —W. B. SAUNDERS COMPANY, Philadelphia, Pa.
- 26 —CAMEL CIGARETTES, New York, N.Y.
- 27 —MEAD JOHNSON & COMPANY, Evansville, Ind.
- 28 —G. D. SEARLE & CO., Chicago, Ill.
- 29 —THE MALTINE COMPANY, New York, N.Y.
- 30 —THE DOHO CHEMICAL CORPORATION, New York, N.Y.
- 31 —PITMAN-MOORE COMPANY, Indianapolis, Ind.
- 32 —THE DICK X-RAY COMPANY, INC., St. Louis, Mo.
- 33 —GERBER PRODUCTS COMPANY, Fremont, Mich.
- 34 —E. R. SQUIBB & SONS, New York, N.Y.
- 35 —CIBA PHARMACEUTICAL PRODUCTS, INC., Summit, N.J.
- 36 —AKRON SURGICAL HOUSE, INC., Indianapolis, Ind.
- 37 —LEDERLE LABORATORIES, INC., New York, N.Y.
- 38 —M AND R DIETETIC LABORATORIES, INC., Columbus, Ohio.
- 39 —PET MILK SALES CORPORATION, St. Louis, Mo.
- 40 —A. S. ALOE COMPANY, St. Louis, Mo.
- 41 —ELI LILLY AND COMPANY, Indianapolis, Ind.

**Booth
Number**

- 42-43-44—WYETH INCORPORATED, Philadelphia, Pa.
(S. M. A. CORPORATION)
(PETROGALAR LABORATORIES)
(THE BOVININE COMPANY)
(REICHEL LABORATORIES)
(JOHN WYETH AND BROTHER)
- 45 —MERCK AND COMPANY, INC., Rahway, N.J.
46 —THE BORDEN COMPANY, New York, N.Y.
47 —THE C. V. MOSBY COMPANY, St. Louis, Mo.
48 —THE MEDICAL PROTECTIVE COMPANY, Fort Wayne, Ind.
49 —HOLLAND-RANTOS COMPANY, INC., New York, N.Y.
50 —AYERst, McKENNA & HARRISON, LTD., Rouses Point, N.Y.
51 —CAMERON SURGICAL SPECIALTY CO., Chicago, Ill.
52 —F. E. YOUNG AND COMPANY, Chicago, Ill.
53 —SPENCER, INC., New Haven, Conn.
54 —THE COCA-COLA COMPANY, Atlanta, Ga.
55 —NATIONAL LIVE STOCK AND MEAT BOARD, Chicago, Ill.
56 —BOWEN-MAHAFFEY INS. AGENCY, Indianapolis, Ind.
61 —MANHATTAN EYE SALVE COMPANY, Louisville, Ky.
62 —THE KELLEY-KOETT MFG. COMPANY, INC., Covington, Ky.
63 —HYNESON, WESTCOTT & DUNNING, INC., Baltimore, Md.
64 —SINGER SEWING MACHINE COMPANY, New York, N.Y.
66 —THE MENNEN COMPANY, Newark, N.J.
67 —ABBOTT LABORATORIES, North Chicago, Ill.
68 —CURTIS AND FRENCH, Indianapolis, Ind.
69 —THE ARMOUR LABORATORIES, Chicago, Ill.
70 —WHITE LABORATORIES, INC., Newark, N.J.
71 —THE SEVEN UP BOTTLING COMPANY, Indianapolis, Ind.

Booth 1**BILHUBER-KNOLL CORP.
Orange, New Jersey**

Metrazol, Theocalcin and Dilaudid play an increasingly important role in today's medicine. Theocalcin is finding greater use in the treatment of rheumatic heart disease. The oral administration of Metrazol in heart block is of interest, as is the use of Dilaudid for quick pain relief. For latest information on Bilhuber products visit us at Booth No. 1.

Booth 2**GENERAL ELECTRIC X-RAY CORPORATION
Chicago, Illinois**

We will be very happy to welcome all visitors at our Indiana State Medical Meeting booth. Mr. J. H. Standard, Mr. R. C. Johnston, and Mr. Louis Clasen will be there to answer any questions that might be asked and render whatever service may be needed.

We will have a very interesting display of x-ray films as well as new x-ray accessories and supply items. Due to present conditions, we have no x-ray equipment available for exhibit.

Booth 3**DUREX PRODUCTS, INCORPORATED
New York City**

The Durex Products' exhibit will emphasize materials essential for the science of contraception. It will feature

Durex Jellies, namely, Lactikol B, Metakol and Contragene, and also Durex Lactikol Creme, as well as the various types of Durex Occlusive Diaphragms, including the Coiled Spring, the Mensinga, the Bow-Bend and the Duraflex Corrective Diaphragms, and other products.

Latest authoritative charts on the technique of diaphragm use and fitting may be obtained at our booth at the exhibit.

Booth 4**ZIMMER MANUFACTURING COMPANY
Warsaw, Indiana**

The Zimmer Manufacturing Company will exhibit a full line of splints and bone instruments. The Corbett Finger and Thumb Splints, and also the new Stryker Screw Driver will be featured among the new items on display. Complete demonstrations of the Zimmer Reduction-Retention Apparatus will be given upon request, and pictures showing the results of its use will be on display.

Booths 5 and 6**SCHENLEY LABORATORIES, Inc.
Lawrenceburg, Indiana New York City**

Schenley Laboratories, Inc., will have an interesting and informative exhibit portraying the clinical indications and administration of Penicillin **Schenley**. Included are color photographs of patients successfully treated. A series of pictures illustrates the manufacture, standardization, and testing of Penicillin **Schenley** at the Laboratories at Lawrenceburg, Indiana.

Booth 7**GRUNE & STRATTON, INC.
New York City**

Grune & Stratton, Inc., Medical Publishers—Booth 7—Exhibit will comprise an established list of titles by foremost writers presenting the latest advances in research and practice. The recent publications—Lichtwitz's "Pathology and Therapy of Rheumatic Fever," Sigler's "The Electrocardiogram, Its Interpretation and Clinical Application," Deutsch's "Psychology of Women," Spiegel-Sommer's "Neurology of the Eye, Ear, Nose, and Throat," Lindner's "Rebel Without a Cause, the Hypnoanalysis of a Criminal Psychopath," Rafferty's "Artificial Pneumothorax in Pulmonary Tuberculosis"—which were published during the last six months and have won wide commendation, and are used as practical reference volumes.

Booth 8**SHARP & DOHME, INCORPORATED
Philadelphia, Pennsylvania**

Sharp & Dohme will have their display at Booth No. 8, featuring their new sulfonamide, Sulfamerazine, and also "Sulfasuxidine," "Lyovac" Normal Human Plasma, Tyrothricin Concentrate (Human), "Depropanex," "Delvinal" Sodium, "Propadrine" Hydrochloride products and "Lyovac" Tetanus Antitoxin, Bovine. Capable, well-informed representatives will be on hand to welcome all visitors and furnish information on Sharp & Dohme products.

Booth 9**SCIENTIFIC SUGARS COMPANY
Columbus, Indiana**

Scientific Sugars Co., Booth No. 9, will display Cartose, Hidex and the Kinney line of nutritional products. The company representatives will be in attendance for the purpose of serving the physicians that stop at the booth.

Booth 16

**BLUE CROSS HOSPITAL SERVICE.
MUTUAL HOSPITAL INSURANCE, INC.
Indianapolis**

Mutual Hospital Insurance, Inc., recently organized by the Indiana Hospital Association, is one of seventy-seven Blue Cross Hospital Service Plans operating in the United States and Canada, with the approval of the American Hospital Association.

The circular emblem of the American Hospital Association, superimposed upon a blue cross, is the insignia of Blue Cross Plans. Permission for its use is assurance to the public that the organization is non-profit in nature, operating under community sponsorship with sound fiscal policies and high ethical standards.

Through Blue Cross more than 4,000,000 people have been relieved of hospital bills amounting to about \$200,000,000.00; 500,000 babies have been brought into the world without hospital expense to their parents.

The service is made available to employed people through their places of employment and makes it possible for a man to protect himself and his family against the unpredictable expense of hospitalization for as little as \$1.50 a month.

Booth 17**DAIRY COUNCILS OF INDIANA**

Stop at the Milk Bar for a free bottle of milk—all that is needed is a thirst for some good cold milk. The Milk Bar is being sponsored by the National Dairy Council Units in Indiana—

Dairy Council of Kokomo.

Fort Wayne Milk Council.

St. Joseph Valley Unit of the National Dairy Council, South Bend.

Dairy Council of Evansville.

Dairy Council of Elkhart.

Dairy Council of Indianapolis.

Booth 18

**AMES COMPANY, INC.
Elkhart**

Demonstration of urine-sugar analysis by the new Clinitest Tablet Method—simple, reliable, fast, single tests being made in less than one minute. A sensitive qualitative test giving dependable quantitative estimations up to 2%.

The Clinitest Tablet Method is a copper-reduction test. Reagent tablet generates its own heat within the test tube.

Booth 19

**THE MAX WOCHER & SON COMPANY
Cincinnati, Ohio**

The Max Wocher & Son Company will be on hand, as usual, with a complete line of surgical instruments, furniture and supplies. Wocher representatives will be pleased to aid physicians whenever possible.

Booth 20

**ORTHO PRODUCTS, INCORPORATED
Linden, New Jersey**

Ortho's exhibit will feature their Council-Approved products for the control of conception. Booklets, reprints, et cetera,

dealing with the various methods, will be distributed. Ask for the recently-published physicians' booklet, "Studies in Human Fertility," which deals with the many aspects of fertility control.

Booth 21

**SCHERING CORPORATION
Bloomfield, New Jersey**

Schering Corporation, in line with their policy of bringing out the latest in endocrine research, is featuring the new estrogenic product—Estinyl Tablets.

Estinyl, a derivative of the natural hormone alpha-estradiol, is most economical and is orally effective in dosage of .02 and .05 mg. It produces very little nausea and toxic side effects.

Other Schering preparations on display will be Oretone-F Pellets, Oretone, Oretone-M Tablets, Progynon-B, Pranone, Proluton, and Cortate, and the diagnostic products for X-Ray—Neo-Iopax and Priodax.

Booth 22

**C. B. FLEET COMPANY
Lynchburg, Virginia**

Phospho-Soda (Fleet), an ethical product for over half a century—a saline eliminant.

What may you, as a physician, expect from this stable, non-toxic concentrate of the two U.S.P. sodium phosphates?

1. Accurate dosage, regulated to the patient and to his condition.
2. The maximum therapeutic effectiveness of sodium phosphate.
3. Quick, gripeless evacuation, for emergencies.
4. Mild, controllable elimination, for chronic biliary disturbance or constipation.
5. Unusual freedom from after-irritation, with normalizing buffer action.
6. Safe action with administration of the sulfonamides.

Are you getting the full value of medication in your daily problems of elimination?

Booth 23

**PHILIP MORRIS & COMPANY, LTD., INC..
New York City**

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Booth 24

**PARKE, DAVIS & COMPANY
Detroit, Michigan**

You will find displayed at the PARKE-DAVIS BOOTH many outstanding Pharmaceuticals and Biologicals. Included in this Technical Exhibit are such noteworthy products as PHEMEROL, a new type of germicide and antiseptic; ADRENALIN PREPARATIONS; MAPHARSEN; THEELIN; DESPECIATED ANTI-TOXINS; also other therapeutic agents of current interest. You are cordially invited to visit this Exhibit.

Booth 25**W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania**

This publishing house will exhibit their complete line of books. Included among the new and important books to be shown are: Bockus' 3-volume work on "Gastro-enterology," 5th edition of Christopher's "Minor Surgery," Erich & Austin's "Traumatic Injuries of Facial Bones," Hoffman's "Female Endocrinology," Moll's "Aesculapius in Latin America," Orr's 1-volume "Operations of General Surgery," Pullen's "Medical Diagnosis," 20th edition of the American Illustrated Medical Dictionary, 3rd edition of Stokes, Beerman & Ingraham's "Syphilology," Cecil's "Medicine," Wharton's "Gynecology and Female Urology," Robertson's "Hydronephrosis and Pyelitis of Pregnancy," McCombs' "Internal Medicine in General Practice," the Military Medical and Surgical Manuals, Solomon & Yakovlev's "Military Neuropsychiatry," Sharr & Kreuz' "Treatment of Fractures by External Skeletal Fixation," Official U. S. Public Health Service Industrial Hygiene Manual, Strieglitz's "Geriatrics," Weiss & English's "Psychosomatic Medicine," and many others.

Booth 26**CAMEL CIGARETTES
New York City**

Camel Cigarettes will exhibit large detailed photographs of equipment used in comparative tests of the five largest-selling brands of cigarettes. Dramatic visualization of nicotine absorption in the human respiratory tract from cigarette smoke will be demonstrated. International news with the Camel Cigarette Trans-Lux "Flash Bulletins" may be seen while enjoying a supply of slow-burning Camel Cigarettes.

Booth 27**MEAD, JOHNSON & COMPANY
Evansville, Indiana**

"Servamus Fidem" means We Are Keeping the Faith. Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pabulum, Oleum Percomorphum and other infant diet materials—including the new pre-cooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booth No. 27 will be time well spent.

The representatives who will be in attendance are:

Mr. P. G. Bicknell
Mr. O. L. Miller

Booth 28**G. D. SEARLE & CO.
Chicago, Illinois**

G. D. Searle & Co. will show a number of the new products of Searle Research which has contributed so much to the recent armamentarium of the physician.

Products such as Searle Aminophyllin, Metamucil, Ketochol, Furmerane, Floraquin, Gonadophysin, Tetrathione, and Pavatine are results of this research which has been greatly expanded in the new Searle Research Laboratories.

An illustration of the new Laboratories will be featured in the exhibit.

Booth 29**THE MALTINE COMPANY
New York City**

The Maltine Company will have on display many of the products for which they have been known since 1875—MALTINE WITH COD LIVER OIL, MALTINE PLAIN, and MALTOYERBINE. Also displayed will be newer products which are the result of the latest research undertaken at their Research Laboratories, particularly PROLOID, TEDRAL, and DEPANCOL.

Booth 30**THE DOHO CHEMICAL CORPORATION**

New York London Montreal

The Auralgan Exhibit consists of a model of the human auricle four feet high together with a series of twenty-four three-dimensional ear drums, modelled under the supervision of outstanding otologists. Each of these drums depict a different pathologic condition based upon actual case observation and prepared, in so far as possible, with strict scientific accuracy so as to be highly instructive and interesting to all physicians.

Booth 31**PITMAN-MOORE COMPANY
Indianapolis**

Pitman-Moore Company is bringing to the Indiana meeting the very attractive display which created so much favorable comment at the American Medical Association meeting in Chicago. Based on the theme: Medical Advancement through Research, the display features illuminated pictures of many interesting research procedures, exhibited on revolving drums.

Products shown will include many biological and pharmaceutical products for prophylaxis and therapeutics.

During the meeting, the Company's Indiana representatives will be on hand to meet their many friends in the medical profession, and members of the research and production staffs will be present to discuss the recent advances in medicine, both as to biological and pharmaceutical products.

Booth 32**THE DICK X-RAY COMPANY**

St. Louis, Missouri Indianapolis, Indiana

The Dick X-Ray Company will have a limited amount of equipment in its booth at this meeting, due to the present regulations on the manufacture of medical apparatus. If possible, we will have some Liebel-Flarsheim short-wave diathermy equipment, with the possibility of several other items of physio-therapy apparatus and x-ray accessories. We will, however, have our representatives present at this meeting, and they will welcome the opportunity of discussing with you any problem that you may have regarding x-ray or physio-therapy equipment. So please visit our booth so that we can at least say "Hello" to you.

Booth 33**GERBER PRODUCTS COMPANY
Fremont, Michigan**

Gerber's CEREAL FOOD AND STRAINED OATMEAL, special infant cereals, are enriched with vitamins of the B-complex and with iron. One ounce supplies nearly twice the day's minimum requirement of both thiamine and iron. The various types of Gerber literature, designed for professional use only or for use with mothers, is available for your inspection.

Booth 34**E. R. SQUIBB AND SONS
New York City**

Physicians attending the Indiana State Medical Association meeting are cordially invited to visit the Squibb Exhibit, Booth No. 34. Several new items will be shown. Among them is Intocostin, the standardized Purified Curare Extract now widely used to soften convulsion in shock therapy; a new, highly useful therapeutic multi-vitamin preparation; a sulfathiazole-ephedrine-derivative combination for ophthalmic use.

Booth 35**CIBA PHARMACEUTICAL PRODUCTS, INC.****Summit, New Jersey**

Physicians are invited to attend our display at Booth No. 35. Featured will be METANDREN LINGUETS, acclaimed by many doctors as a very potent androgenic substance for sublingual use. Clinical investigations indicate that this method of sublingual administration results in greater potency. Also PRIVINE, a powerful nasal vasoconstrictor of prolonged action; NUPERCAINE, a spinal anesthetic; BIOTOSE, a combination of water-soluble vitamins together with phytin and liver extract; and VIOFORM, a non-irritating antiseptic.

Samples and literature will be available, and representatives will be in attendance to answer any questions you may have in regard to Ciba specialties.

Booth 36**AKRON SURGICAL HOUSE, INC.****Indianapolis**

The Akron Surgical House, Inc., will have an exhibit in Booth No. 36 at the convention of the Indiana State Medical Association to be held in Indianapolis on October 3 and 4.

E. C. Clark will have charge of our display, in which will be shown the latest developments in the line of surgical instruments and equipment. Some of the items in our drug and pharmaceutical department, which we added a year ago by acquisition of a complete apothecary, will also be displayed.

Booth 37**LEDERLE LABORATORIES, INCORPORATED****New York City**

A cordial invitation is extended to members and their guests to visit the Lederle exhibit at Booth No. 37. We will display our complete vitamin line, certain biological items, Cerevim (our pre-cooked whole grain cereal) and will possibly exhibit blood plasma and penicillin.

Lederle representatives will be on hand to welcome visitors and discuss our products.

Booth 38**M & R DIETETIC LABORATORIES, INC.****Columbus, Ohio**

Similac, a powdered modified milk product especially prepared for infants deprived either partially or entirely of breast milk, will be displayed by M & R Dietetic Laboratories, Inc., Booth 38. Mr. Wheeler, who will be in charge, will appreciate the opportunity to discuss the merit and suggested application of Similac for both the normal and special case.

Booth 39**PET MILK SALES CORPORATION****Saint Louis, Missouri**

A complete display of material illustrating the time-saving Pet Milk services available to physicians. Specially-trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

Booth 40**A. S. ALOE COMPANY****St. Louis, Missouri**

A. S. Aloe Company, in Booth 40, will exhibit a cross-section of their complete line of surgical and laboratory instruments, equipment, and supplies. Featured will be American-made stainless steel surgical instruments, which are again available,

as well as such Aloe specialties as Radcliff Retractor for unassisted perineal repair, the Goth set for rapid testing of sulfonamide concentration in the blood, etc. It will be a pleasure to welcome you at the Aloe Booth.

Booth 41**ELI LILLY AND COMPANY****Indianapolis**

The Lilly exhibit will feature an anatomical model illustrating the technics of caudal and spinal anesthesia. Lilly products will be on display, and medical service representatives will be present to assist visiting physicians in every possible way.

Booths 42, 43 and 44**WYETH INCORPORATED****(S.M.A. Corporation Division)****Philadelphia, Pennsylvania**

Up-to-the-minute information on Infant Feeding and Nutritional Biochemicals can be obtained at the S.M.A. Corporation exhibit. Of particular interest to most physicians is the new protected Vitamin A product, CARITOL.

WYETH INCORPORATED**(John Wyeth and Brother Division)****Philadelphia, Pennsylvania**

You are cordially invited to visit the Wyeth exhibit where Bepron, Amphojel, Phosphajel, Kaomagma, Silver Picrate, B-Plex and other pharmaceutical specialties will be featured.

WYETH INCORPORATED**(Reichel Division, Biologicals)****Philadelphia, Pennsylvania**

You are invited to visit the Biological Division exhibit where representatives will be pleased to explain the uses of the Wyeth Allergenic Diagnostic Equipment.

Booth 45**MERCK & CO., INC.****Rahway, New Jersey**

Penicillin, the drug of greatest potential interest today, will be the main subject of the Merck exhibit. Literature will be available. The display will illustrate the growth of the mold, Penicillium notatum, the method of its assay, and other interesting features. Other products that the Merck representatives will be pleased to discuss with you are Tryparsamide for neurosyphilis; the inhalation anesthetic, Vinethene; Erythrol Tetranitrate for hypertension; Myochrysine for rheumatoid arthritis, and Pyridium for symptomatic relief in genitourinary infections.

Booth 46**THE BORDEN COMPANY****New York City**

Visit the Borden Booth and learn about the new infant foods of unsurpassed quality. Biolac, the distinctive new liquid infant food, affording convenience, economy, and optimal nutrition, is now packaged in the new 13-ounce war-time tin. Stop by for feeding directions! New Improved Dryco affords quicker solubility, lower cost, and increased vitamin potencies. Use Dryco for formula flexibility. Mull-Soy is the emulsified soy bean food for infants, children and adults allergic to milk—highly nutritional, exceptionally palatable and easy to serve. Borden's Beta Lactose is nature's carbohydrate in an improved, readily-soluble form.

Booth 47**THE C. V. MOSBY COMPANY
St. Louis, Missouri**

New books and new editions to be displayed by the C. V. Mosby Company at the convention of the Indiana State Medical Association will include Dodson "Urological Surgery," Meakins "Practice of Medicine," Bellows "Cataract and Anomalies of the Lens," Pottenger "Symptoms of Visceral Disease," Kuhn "Industrial Ophthalmology," McCormick "A Textbook of Pathology of Labor, Puerperium, and the New-born," Selling "Synopsis of Neuropsychiatry," Herrmann "Synopsis of Diseases of the Heart and Arteries," Titus "Management of Obstetric Difficulties," Davison "Synopsis of Materia Medica, Toxicology and Pharmacology," and Bray "Synopsis of Clinical Laboratory Methods." You are cordially invited to visit our booth where our representative will be glad to discuss your book needs with you.

Booth 48**THE MEDICAL PROTECTIVE COMPANY
Fort Wayne, Indiana**

The professional liability risk of the doctor cannot be given an underwriting classification with any other type or types of insurable hazards, without disadvantage to the doctor. The circumstances out of which arise the reciprocal rights and duties of a doctor and his patient are peculiar to their relationship; the interest of the doctor in the management and disposal of charges of negligence against him is not to be compared with that of any other class of damage suit defendants. The most exacting requirements of adequate liability protection are those of the professional liability field.

The Medical Protective Company is exclusively engaged in that field.

Our representative, thoroughly trained in professional liability underwriting, invites you to confer with him at exhibit Booth No. 48.

Booth 49**HOLLAND-RANTOS COMPANY, INC.
New York City**

A cordial invitation is extended to all attending physicians to visit the Holland-Rantos Company, Inc., booth where on display will be the complete Koromex line. Featured this year is the Koromex Set Complete—the outstanding complete unit for contraceptive technique. Professional representatives will be pleased to supply you with all the information on the use of this set, and other products.

Copies of the Dickinson-Fraser fitting charts will be given to all interested physicians.

Booth 50**AYERST, McKENNA & HARRISON, LIMITED
Rouses Point, N. Y. Montreal, Canada**

"Premarin," a highly-potent, orally-active, naturally-occurring complex of conjugated estrogens will be featured.

This product has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association and is the culmination of ten years of intensive research.

Two new pertussis products will also be displayed, one for prophylaxis and the other for treatment of the active stages of whooping cough. These are based on the principle that the endotoxin of the *H. pertussis* organism is important in the etiology of the disease.

Booth 51**CAMERON SURGICAL SPECIALTY COMPANY
Chicago, Illinois**

See the Cameron Flexible Gastrosopes and Cavi-camera, the new Cameron Coagulo-Sigmoidoscope, Electro-Diagnoscopes, Bronchoscopes-Esophagoscopes-Laryngoscopes, Binocular Prism Loupe, Mirrolite, Magniscope and other new developments in electrically-lighted diagnostic and operating instruments. Cameron Electro-Surgical Units will also be on display. Represented by W. E. Mettler.

Booth 52**F. E. YOUNG & COMPANY
Chicago, Illinois**

Manufacturers of Young's Rectal Dilators. The dilator set consists of a series of four bakelite dilators, graduated in size and introduced in series as the rectum becomes accustomed to dilatation. Rectal dilatation is used by physicians to treat certain cases of constipation, dysmenorrhea, rectal neurosis, uncomfortable bowel movement, and other conditions which may arise due to a tight or spastic sphincter muscle.

Booth 53**SPENCER INCORPORATED
New Haven, Connecticut**

You are cordially invited to visit our booth, featuring individually-designed supports for abdomen, back and breasts. You will be especially interested in the scientific service for patients who have undergone mastectomy, and in the spinal support as an aid to treatment of back conditions where immobilization is desired. Also on display are supports for hernia, visceroptosis with symptoms, postoperative, obesity, various conditions causing low back pain, maternity and postpartum wear as well as for many breast conditions.

Capable Spencer representatives will cheerfully explain the supports and answer questions.

Booth 54**THE COCA-COLA COMPANY
Atlanta, Georgia**

"Coca-Cola" will be served to the delegates with the compliments of The Coca-Cola Company.

Booth 55**NATIONAL LIVE STOCK AND MEAT BOARD
Chicago, Illinois**

Visit Booth No. 55 and see the charming, illustrated nutrition book for children; entitled "You and Your Engine," which is part of a Teaching Kit on Nutrition for Elementary Schools that has just been published by the National Live Stock and Meat Board and is now ready for distribution. This book, plus a new set of charts in full color, the Nutrition Yardstick, and other educational literature will be displayed.

Booth 56**BOWEN-MAHAFFEY INSURANCE AGENCY
Indianapolis**

Booth No. 56 will be occupied by the Bowen-Mahaffey Insurance Agency, 111 North Pennsylvania Street, Indianapolis. The Agency will be very glad to consult with any doctor concerning the new group malpractice policy approved by the Executive Committee of the Indiana State Medical Association.

Booth 61**MANHATTAN EYE SALVE COMPANY**
Louisville, Kentucky

The practice of supplying Ophthalmic Ointments for the exclusive use of oculists and physicians, put up in pointed tip tubes of pure block tin, was originated by this Company in 1900.

Since that time we have devoted our entire attention to this one line of manufacture, and we feel that we are in better position to serve you than companies manufacturing varied lines of drugs and chemicals.

All ointments bearing the M.E.S. label are guaranteed to conform to Federal laws and A.M.A. rules governing standards and purity of this type product.

Booth 63**HYNSON, WESTCOTT & DUNNING, INC.**
Baltimore, Maryland

Hynson, Westcott & Dunning will have a representative line of their well-known therapeutic and diagnostic specialties—including Mercurochrome, Thantix Lozenges, Bromsulphalein, Lutein Ampules, Thyroid Tablets, Phenolsulfonephthalein Ampules and Colorimeters and Sulfanilamide 5 gram Sterile Shaker Envelopes, such as are being supplied to the U. S. Army and Navy, on display. Messrs. Hughes and Shepherd, laboratory representatives, will attend the booth.

Booth 64**SINGER SEWING MACHINE COMPANY**
New York City

The Singer Sewing Machine Company takes pride in presenting its Surgical Stitching Instrument for the advancement of surgery. The instrument brings unprecedented speed, facility, and versatility to the suturing phase of surgical work. It feeds suturing material continuously from a spool held under ready thumb-control. It unites needle, needle holder, suture supply, and severing edge in one self-contained instrument, sterilizable as a complete unit.

This precision-made instrument—so versatile in making a variety of stitches old and new to surgical technique—can employ any standard suturing material, or be fitted from a wide variety of available needle sizes, shapes, or styles, for use in either a deep or superficial field.

The Singer instrument need never leave the surgeon's hand during stitch-placing or tying, even cutting being done with the lance point needle. An early investigation of the many advantages of this unique suturing device and the numerous new stitches it facilitates is suggested.

Booth 66**THE MENNEN COMPANY**
Newark, New Jersey

The Mennen Company will exhibit their two baby products—Mennen Antiseptic Baby Oil and Mennen Baby Powder—Antiseptic, in addition to their fungicidal foot powder—Quinsana.

The Antiseptic Oil is now being used routinely by more than 50 per cent of the hospitals that are important in maternity work.

Be sure to register at the Mennen exhibit for the lucky Number Prize Drawing to be held on the last day of the convention.

Booth 67**ABBOTT LABORATORIES**
North Chicago, Illinois

Abbott-trained representatives in attendance look forward eagerly to meeting you here. This comprehensive showing of the well-established Abbott specialties includes a number of newer products, such as Desoxyn, Trynazin, Dicumarol, Cecon (10% Sol. of vitamin C) for drop dosage to infants, Vijectin, etc. A hearty welcome awaits you here!

Booth 68**CURTIS AND FRENCH**
Indianapolis

Curtis and French, 510 North Capitol Avenue, Indianapolis, Indiana, the new surgical supply store, will be representing all the nationally-known lines and will be very happy to inform you as to what is available. Jack Curtis and Jerry French will have charge of the booth. Drop in often.

Booth 69**THE ARMOUR LABORATORIES**
Chicago, Illinois

The Armour Laboratories extend a cordial invitation to members of the Indiana State Medical Association to visit the Armour exhibit—Booth 69.

Representatives will welcome an opportunity to discuss recent developments in the field of endocrinology.

The new Armour book, "The Thyroid Gland and Clinical Application of Medicinal Thyroid," is available to members of the association visiting this exhibit.

Representatives in attendance are Robert H. Andrew, H. A. Berry and H. V. Brown.

Booth 70**WHITE LABORATORIES, INC.**
New York City

At the White Laboratories' Booth No. 70 you will find interesting copies of a series of publications under the general title "Diagnostic Aids to Vitamin Deficiency Conditions." Medical Service Representatives in attendance will be very glad to discuss these with you.

The latest clinical reports on results of the use of White's Vitamin A and D Ointment in the treatment of burns and various types of ulcers will also be available. This is a product which you will undoubtedly find of great interest.

Booth 71**THE SEVEN-UP BOTTLING COMPANY**
Indianapolis

Tom Joyce, Owner and General Manager of The Seven-Up Bottling Company of the State of Indiana, welcomes the physicians of Indiana to view his exhibit at the State Meeting, October third and fourth.

Mr. Joyce owns and operates plants in Evansville, French Lick, Gary, Kokomo, Fort Wayne, and Indianapolis. All plants have special equipment for the treating of water, and the finest sterilizing and bottling machinery that can be had. The ingredients are proudly stated on each bottle of 7-Up, because the bottlers of 7-Up are proud of its quality, and believe in telling the public the good things that go into the making of 7-Up. Seven-Up is more readily retained in certain cases of illness. It gives a gentle massage to the walls of the stomach, whereas cold water settles heavily in the bottom of the stomach. Seven-Up feels light, and is light on the stomach, yet satisfying.

THE JOURNAL OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

Copyright, 1944, Indiana State Medical Association

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Indianapolis 4, Indiana

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SEPTEMBER, 1944

Editorials

THE WINGS HAVE IT!

The 1944 session of the Indiana State Medical Association will be turned over to the Air Corps, bag and baggage. Indianapolis will be entertaining a large group of medical men whose present job it is to see that the medical department of the Air Corps is properly manned—and it is just that—manned by the best-trained group of “air specialists” in the wide world, for be it known that the medical department of the United States armed forces is superior to any similar group in any nation.

This session, as Tom Hendricks put it the other day, will be a “humdinger.” We have had marked successes in all our annual gatherings, but 1944 promises to outdo all previous efforts.

We wish we might be able to demonstrate the cooperation we have had from the Air Corps in the preparation of the program; we do not recall a single year, and we have been somewhat active in convention plans in Indiana for more than forty years, when we have had such loyal support. All of the papers to be presented by this group were in early and even now are typeset, all ready to go.

These are really *good* papers; each presenting some live, up-to-the-minute material; they tell us what our medical buddies are doing in every part

of the world; and they tell us of the enormous advances that have been made in medicine and surgery in these times of war. No physician could go away from a meeting such as this without feeling that he had heard the best.

Indiana Medicine, long known as a famous host, will outdo itself this year; we will send these representatives of the Air Corps back to their respective stations feeling that they have been royally entertained and that they have been communing with a live bunch of medical men.

Little need be said as to the accomplishments of the Air Corps of our Army and Navy; it is *the* outstanding success of the war, and without its marvelous work we still would have years of fighting ahead of us.

We have honored the Army and Navy at previous meetings; now we welcome the Air Corps with open arms; we greet men who have been in *active* service in the various theatres of war, men who have been “up front” where they had first-hand information of what has been going on, medically and surgically. They will tell us of the marked reduction in mortality among our fighting forces and will tell us just what has brought this about.

All honor to the Air Corps and its various heads. We do not mention specific names, because if we attempted to name all the men who have done this marvelous work we would need a special edition of THE JOURNAL. Suffice to say, we have an enormous respect for this group and an abiding faith that they will continue to come through. THE WINGS HAVE IT!

OUR PRESIDENT

Jacob Thomas Oliphant, M.D., is a Hoosier, having spent all his active, energetic, go-getting life in the State of Indiana. Born at Buena Vista, Monroe County, the son of Reverend James H. Oliphant, a minister of the Baptist faith, and Catherine Teague Oliphant, he moved with his family to Crawfordsville when a lad of ten years. Later the family was transferred to Pimento, in Vigo County, then back to Crawfordsville.

About this time “Jake,” as he is known to every Indiana physician, had a hankering for an education. It seems as though he had thought of being a pedagogue at this time, so he spent one year at the Indiana State Normal College, at Terre Haute. Then he concluded his collegiate education at Wabash College, later entering the Medical College of Indiana, and graduating therefrom in 1905.

A few months later he married Miss Fredonia Alice Campbell, of Crawfordsville, and at once set out for Farmersburg, Sullivan County, where he opened an office for the practice of the healing arts. He has remained in that community ever since—a matter of some thirty-nine years—which in itself is a worth-while recommendation for any physician.

He has two sons, Dr. Joseph F., associate professor of Biology at Stanford University, and Dr. Robert W., now with the Thirty-second General Hospital.

Jake was stationed at Fort Riley, Kansas, during World War I. He was commissioned a member of the Indiana State Board of Medical Registration and Examination, by former Governor Townsend, in 1937, resigning from that post in 1941. During that time he served as president of the board for some three years.

He has been president of the Sullivan County Medical Society on four different occasions. It seems that when innocuous vicissitude falls upon that society (which is not often because that little group is one of the live wires of Indiana), they just put Jake back on the job.

He has served for more than twenty-five years as the delegate from his county, and long since acquired the enviable title, "The Perfect Delegate." One time we dared ask Jake about that title—just wondered about it. His answer was, "Sure, I am the perfect delegate; I admit it!"

He states that he is a Democrat—says nothing about being a New Dealer, however; and that he is a Baptist. In a personal communication, he says, "I have been fairly active in civic and political affairs in Sullivan County." (Modesty, personified, that is!)

We have known Jake Oliphant for more than the twenty-five years he admits having served in the House of Delegates; we have worked with him; we have, on occasion, battled with him, and we have taken more than one lickin' at his hands. Jake is of a rather reticent type; he does not rush into a debatable matter until he has thoroughly digested the thing; then, if he feels the urge, he speaks. And when that man speaks he has an audience, for those of us who have been active in the affairs of the state association for many years have long since come to have a most wholesome respect for his remarks.

At the mid-winter meeting of the Council, last January, President Oliphant was called upon for a report from the President; on many occasions this report has been a perfunctory affair, but not on this occasion. In a few brief words Jake gave us a lot to think about. Personally, we felt it was the best speech we ever had heard from a medical man. His report was immediately selected as material for the "School for Speakers" to be held the following March. It probably was the most widely-read pronouncement of any Indiana physician.

As the representative head of Indiana Medicine for 1944, Jake Oliphant has had a big job before him, and has done it exceedingly well. His analysis of many intriguing problems at times has been uncanny. "Just a country doctor," Jake terms himself, but we of Indiana know him for what he is—a big, broad-shouldered chap, not too talkative, but one who sits in a meeting *absorbing* what is going on; then, if the spirit moves him, he gives the answer in a few scrupulous words.

We know of no man in Indiana who has all the abilities of Jake Oliphant, and who knows so well how and when to use them. The Indiana State Medical Association is, indeed, most fortunate in having had such a man as its leader in the parlous months of 1944.

BASIL MITCHELL TAYLOR

"B. M." has gone, and with his passing Indiana Medicine loses one of its landmarks, one of its most resourceful members. He had reached the age of seventy-four, but continued his daily duties with vigor and enthusiasm that should be the envy of younger men. Few men in the Indiana profession have contributed more to his local community than Dr. B. M. Taylor. From the editorial comment in his home-town paper, from the comments of his confreres, and from the sermon delivered by his pastor, the Rev. Theodore O. M. Wills, of the First Presbyterian Church, of Portland, one can but gather that a good man, indeed, has gone.

For many years "B. M." had served as secretary of his local county medical society. His notices concerning meetings were printed on postal cards, each notice carrying one or two Will Rogers-esque comments, the like of which have never appeared in print. From reading these over a long period of years we gained the impression that he was a real student of human nature—and so he was!

In speaking of that phase of his life, his pastor said: "This man understood people and understood human nature so well because he gave his time to the people." One cannot go along, day by day, giving of his time to the people without acquiring a store of knowledge about human nature, and we dare say that "B. M." had a stock of knowledge such as few other men possess.

The editor of the *Portland Commercial Review*, who evidently knew Doctor Taylor intimately, said: "He was humble and deeply religious. His homespun philosophy has never been excelled by any great writer, and his love for his fellow men was something that never will be forgotten by those who knew and loved him."

Dr. Taylor was a great man and a humanitarian. He did not seek fame or riches, for he could have been an outstanding specialist or surgeon. Instead, he chose a small town in which to labor.

We wish we might have known "B. M." more intimately; our contacts with him were in the main a little chat at the annual convention, plus the monthly postal card, always a welcome caller at our desk.

Mrs. Taylor has sent us a quantity of these postal card announcements, and in later issues of *THE JOURNAL* many of these will be used; there is too much wholesome Hoosier philosophy to be lost to future posterity.

Veritably, he was a great man; he lived a busy life, and a most useful one; he enjoyed meeting

folk and conversing with them, and his passing will leave a void in his home community which cannot be filled by another.

"B. M." has gone, but he leaves many monuments, monuments that will endure for years to come.

CONSTITUTION DAY

On September seventeenth the Constitution of the United States will have reached its 154th birthday, and plans have been made for a state-wide observance of this occasion. The Constitution Day Committee is asking that all civic, fraternal, and church organizations take cognizance of this date.

And it is meet that we should venerate this aged document, by far the greatest political writing ever to come from the hand of man. Particularly in these times of stress are we again reminded of the far-sightedness of our forefathers; it would seem that they were endowed with omniscience when this paper was written and adopted, for, no matter what arises in the course of our daily life; no matter what political conditions may confront us, and no matter what international complications threaten, there is the Rock of Gibraltar on which we stand and which seems to have the proper answer for all occasions.

We of America have the healthy habit of remembering important dates in our calendar, days reminding us of epoch-making events in our history, hence we are ready to again celebrate one of the most important dates in our long history.

There have been occasions when we feared that efforts were being made to upset the real meaning of certain sections of that immortal document; occasions when political contrivance seemed on foot for this purpose, but each time that great State Paper has survived the attack and was even more strongly entrenched in our hearts after all was over.

No other document, in this or any other nation, means so much to its people; it guarantees to all, regardless of race, creed or color, equal rights; and by that term, "equal rights," is meant just that, and it is couched in such simple language that anyone can understand it.

We talk of the causes of immigration—why so many millions have come to our shores from foreign countries. We may say that it is because of our wealth and our unlimited possibilities, but this is the wrong slant—the *real* reason why we have added so many millions to our population in years past is because of the *very freedom* guaranteed to all.

Constitution Day, then, merits more than our casual attention; it probably deserves more recognition right now than at any other time in our history. When our nation is at war, we naturally show

a deeper interest in our Constitution—we want to know the answer to this and that, and we get it from that document.

Therefore, it behooves us, on September 17, 1944, to pause a bit and ponder the question, "What does the Constitution mean to me?" The answer is simple; it means *everything*. It means the continuance of that freedom we enjoy, a freedom that few other people have. It means the stabilization and continuance of American progress; in short, it means **EVERYTHING!**

OUR NEIGHBOR TO THE NORTH

Our vacation was spent in the western part of Ontario, Canada, a section to which we have gone over a period of years. Due to violent storms the fishing was not up to par, hence, we had no little time on our hands, which was spent in checking various economic conditions in that part of Canada; it had been a matter of two years since we had visited there.

Canada well knows there is a war on; on every hand this is evident. Yet the populace is busy and seemingly content with the many restrictions necessarily imposed upon them. Employment in this particular area is no problem—everyone seems to have a job to do, and is doing it contentedly. We did not hear a single "gripe" about these things.

While passing through "Customs," we inquired as to the number of folk from the States going into Ontario, vacation bent. We were advised that while the number was less than in pre-war years, there was a steady influx into that country. In former years one could see cars from all over the United States, either parked in the little city at the port of entry or along the highways nearby. Not so in 1944; the only cars noted from this country were a few from the border state of Minnesota, and there were few of them. Tourists going into Canada go by train and by bus, neither of which services are of the pre-war variety; in fact, travel in that direction is not too comfortable.

Fishing parties, after passing Customs, get their first shock when they apply for a liquor permit; in other years the sky was the limit. Now the visitor—and this also applies to local residents—get a permit entitling him to buy thirteen ounces of liquor each month. One may also get a beer permit, which entitles the holder to one case of this product each month.

As to gasoline, that is practically out. The visitor gets a permit to buy four imperial gallons each year, which also applies to the Ontario private-car owner. For his outboard motor one gets three and three-quarters gallons each year. Camp owners and licensed guides have no trouble in getting all the fuel they need for their motors.

We shopped at several of the stores with which we had become acquainted in previous years and

found many restrictions and shortages. A good man's suit was not to be had in the city at the time of our visit. It seems that dealers were allotted so many suits each year, dependent upon sales in former years. A man who operates an up-to-date men's store did not have one suit in the house; said that on September first he would get one hundred fifty suits, and that these would be sold in less than ten days. We checked several stores, at the suggestion of this man, and were unable to locate a single white dress shirt—no more available until September first—and the chap who gets there first gets the shirts!

Food stuffs, in the main, are plentiful and the prices reasonable. We stepped into the ice chamber of several markets and were surprised at the quantity and quality of meats on hand—far superior to what we are accustomed to seeing in this country. Meats are not rationed, nor is cheese, and in this latter item we met with a real surprise. Rare, aged Cheddar is to be had, as well as the Canadian Stilton—plenty old to be delightfully good.

Tea, coffee and sugar are rationed *strictly*. In the hotels and restaurants one gets one cup of coffee, with one helping of sugar, and the waitress doles out the sugar herself—no cheatin'!

The stores that in former years sold immense stocks of the Hudson Bay blankets, Kenwood blankets, all sorts of Irish linens, and English and Scottish woolens, now have bare shelves, one long-time dealer stating that his allotment of blankets was less than two dozen each year.

Government taxes are high in Ontario, as well as in all of Canada. They are trying a new plan of war finance, that of paying as they go. It is generally believed there that at the close of the war the Canadian government will have a clean slate—will not be saddled with hundreds of billions of dollars to be paid by generations to come. Business men told us that their net, personal profit from their business amounted to just what they needed for personal and home expenses—all above that goes to the government—and they are not complaining one whit!

We neglected to mention that local taxis are allotted five American gallons of gas each day; when they are out of gas they are out of business until the following day. They are not permitted to travel more than twelve miles from town.

One of the interesting comments one hears from everyone, the man on the street, the business man, the professional man, and all, is something like this: "The Post-war Canada will be nothing like the Canada of today." They will not elaborate upon that statement to any great length; however, it would seem that Canada in general, and Ontario in particular, is in for an industrial change of no mean proportions.

The finding of almost inexhaustible beds of iron ore of the highest grade, not too far removed from the north shore of Lake Superior, will prove a bonanza of the highest order. Then, too, the

newly-located gold fields, chiefly in the western part of Ontario, promise to add much to the economic wealth of the province.

We have made many visits to various parts of Canada, none of which has opened our eyes as this visit did. The people with whom we came in contact on this visit are a busy, contented lot; they have a job on hand, that of helping win the war; they are doing that job as best they can, and they are not complaining even though their government taxes are three to three and one-half times higher than those applying to this country.

Editorial Notes

In all the casualty reports from the various fronts, the outstanding feature is the extremely low death rate in these groups. In a recent address, Irwin Abell, former president of the American Medical Association, stated, "Many a wounded man who would have been long invalided or permanently disabled in 1919 is quickly and completely healed in 1944. As has been stated many times, this is due to two things—the marked advances in medicine and surgery, plus the addition to armamentarium of several drugs whose action in injury cases is near the miraculous.

Do not overlook this most cogent argument when discussing the matter with some socialized medicine addict—especially if he is in some sort of business—that he, too, is to be "socialized." A lot of these folk have not had it brought to their attention that under the Wagner-Murray-Dingell Bill, six per cent of the employees' wages, plus a like per cent from the employer, will go to make up the billions of dollars required to put over the idea. Most people suddenly awoken to a situation when they learn that it is *their* pocketbook that is to be opened up.

Have you marked the date in your appointment book?—referring, of course, to the annual convention, October 3, 4, and 5, at Indianapolis. This, as you know, is to be the Air Corps party, when "wings" will be very much in evidence. As matters now shape up, this is to be one of the top-notch meetings in our long history. October is probably the best month of the year, in Indianapolis, so far as the weather is concerned and, too, it is an ideal time to get away from your work for a few days. Just one more bit of admonition—better make certain that you have a reservation before you leave home. Hotels, you know, are pretty well filled these days, and an advance reservation will save you many anxious moments. Be seein' you in Indianapolis.

The Woman's Auxiliary is all set for its part in the Indianapolis convention, a full program having been arranged for the occasion. We wish to compliment Mrs. Arthur B. Richter, chairman of Press and Publicity, for her work in getting material together in good time for publication in this number of *THE JOURNAL*—all of which makes it much easier for our staff in assembling the enormous amount of material for our pre-convention issue. Again, thanks Mrs. Richter!

So they've raised the ante! Referring to the chain store opticians about which we wrote in the August number, one of our friends had answered the postal card he had received, and at once had a reply stating that the weekly salary would be *seventy* dollars. A few years ago when we made a personal "application" for one of these jobs, the salary offered was forty dollars; later in the interview this had been increased to sixty dollars.

The current number of *THE JOURNAL* carries reports of all committees as well as those of the officers; in fact, this volume is a resumé of all that has gone on in medical Indiana during the past year. And it makes good reading, since it is most informative. Especially should every member of the House of Delegates read *all* these reports, since everyone of them will come before that body for action, one way or another. We have known sessions of the House in which more than one member unnecessarily consumed a lot of time because he was not informed, when a few minutes time spent in reading the pre-convention reports would have made his questions and arguments unnecessary. Take a little time off and read these reports; you will really be amazed to learn how many of your confreres have spent a lot of time working for *you*.

We believe that medical societies, as well as individuals, should be extremely careful in the matter of commenting on post-war plans for the medical men now in service. These chaps have left their private business, many of them having made great sacrifices. Even the younger group, referring especially to those who were but a few years removed from an internship, had begun to build their medical future. Most of these, practically all of them, plan to come back home once they have been discharged from their war duties. They plan to resume practice rather than to take a "job" of some sort, as all too often has been suggested by ill-advised commentators that they might do. It is true that there will be an increase in appointments to such groups as the United States Public Health Service and other like bodies, but it is our observation that most servicemen want to get back on the home grounds, there to again take up their life work. Let's not be in too big a hurry to decide what is to be done with these men; they are indeed capable of making their own decisions, and they *will*.

Dean Gatch, of the Indiana University Medical Center, is quoted as stating in his annual report to the Board of Trustees that some of the beneficial effects arising from the war period, as it relates to our medical school, are:

1. Improvement in teaching, through a critical review of the school's curriculum.
2. Strengthened friendship with the physicians of the state.
3. Closer cooperation with the Indianapolis City Hospital.

The Dean also takes occasion to say that the cost of medical education for the year ending June thirtieth was but 13 per cent of the total expended by the medical center.

One of the most important committee reports represented in this issue of *THE JOURNAL* is that of the Study Committee on Health Insurance, published on page 501. This report should interest every member of the Association, for it concerns all of us from a social, financial, and economic standpoint. For many years the adoption of a pre-paid sickness insurance plan has been under consideration, so as to forestall the menace which would result from socialized medicine, and here is a report which offers a reasonable solution to the problem—the adoption of a pre-payment medical service plan, sponsored by the Indiana State Medical Association. Every member should read this report—particularly the members of the House of Delegates who should read it well in advance of the meeting so as to familiarize themselves with the proposed plan and be prepared to discuss the program!

Colonel Franklin T. Hallam, of Indianapolis, recently received the Legion of Merit Award for "exceptionally meritorious conduct in the performance of outstanding services as surgeon of a corps, while serving in the South Seas from February 28, 1943, to March 31, 1944. The citation went on to say that Colonel Hallam had contributed greatly to the substantial decrease in the incidence of malaria in that sector and had had much to do with the coordination of Army and Navy services. The Corps Commander, General Harmon, was enthusiastic about the doings of Colonel Hallam and made it clear that this medical officer knew what it was all about and just what to do with each of the many problems that confronted him. Colonel Hallam, who had been overseas for some nineteen months, was granted a rather extensive furlough, most of which he spent in his native city of Indianapolis. For many years he had been associated with Dr. Carleton B. McCulloch, in the capacity of assistant medical director of the State Life Insurance Company. His many Hoosier friends will be more than pleased with the recognition accorded him by his superiors in the armed forces.

Dr. James B. Maple, of Sullivan, long-time exponent of organized medicine, recently addressed the Sullivan Rotary Club, taking as his topic a most unusual-termed subject, "Why Every Man Owes Himself a Birthday Present." As his friends well know, Doctor Maple has in late years showed an intense interest in geriatric problems, and they probably were not surprised when he adopted a subject along these lines for his address to his fellow citizens. For many years he was one of the "wheel horses" in Indiana Medicine, continuing his activities until he acquired a somewhat odd allergy—tobacco—making it extremely unpleasant for him to attend meetings in which such a great amount of the "weed" was being consumed. Press reports indicate that the informative address of Doctor Maple was well received.

The following ad was noted in a recent number of *The Hoosier Democrat*, published at Flora, Indiana:

"This hot weather brings on Cholera Morbus (indigestion). GET OUR REMEDY FOR IT.

"THOMSON'S PHARMACY."

This is the first time we have heard of "cholera morbus" in many years. We used to hear of it frequently, down in Wild Cat, which, by the way, is but a hop, step, and jump from Flora. Druggists *should not* publish such advertisements. When one has an attack of "indigestion" the very first thing he should do is to see his physician, for such an attack may mean a serious condition. The day for such ads is long past; in fact, it will be a matter of a short time when such ads will be prohibited by Federal law.

The Indiana press, along with that of several other states, is becoming concerned over the shortage of hospital facilities in many sections of the country. Various causes for this have been assigned, more than one editor attributing it, in part, to the current shortage of physicians. Then, too, the suggestion is offered that folk keep well; this being accomplished by not too much overwork and the observance of the elementary rules of hygiene. The lack of competent hospital help has much to do with the dilemma we now find confronting us, some hospitals being unable to use all their available sick-bed space due to the manpower shortage. It also has been suggested that steps should be taken to see that patients do not stay "too long" in our hospitals; nursing homes should be established for the convalescent cases. Something concrete should be done, lest our enthusiasm runs away with us, in the creating of too many new institutions which would not be so well occupied once the country gets back to a normal stage.

The *Shelbyville Republican*, staunch believer in medicine, says, "Schemes for the socialization of medicine permit gambling with a large number of votes from people who are of necessity uninformed on the scientific issues involved. Medicine and health should never be a political issue. Medical science and progress know no political limitations." This bears out our long-maintained contention that if we but *inform* our folk of the real meaning of socialized medicine, there never could be such a thing in this country.

We've just gotten around to it, but take this occasion to compliment Dr. Herman L. Kretschmer, recently-installed president of the American Medical Association, for his comment on the "vitamins" in his Presidential Address. Not that we do not believe in the efficacy of vitamins, *properly used*, but because we long have felt that they have been overdone and needed a bit of debunking. As the doctor said, "I do not believe that the people of this country are in such a state of malnutrition as to require \$250,000,000 worth of vitamins." Much of this, of course, is to be charged to the "radio blah" that goes on every day, advising listeners to "go to the drug store right now and get 'Blank's Famous Vitamin Pills,' each containing eight of the well-known vitamins." We wish to once again repeat the comment that if we stop "refining" our foods, taking therefrom the very vitamins the human body most needs, it would not be necessary to go to the druggist to buy, at an enormous price, the vitamins that really belong in our foods and never should be removed in the first place.

Along about this time of the year THE JOURNAL has a perennial complaint—concerning the delay in getting the pre-convention number material into our office on time. Under the best of conditions, the preparation of this number, one of the largest of the year, is an immense task, and when we add to the job the necessity of writing and even wiring for committee reports, it becomes a real job. Then, too, our printer has his own troubles, which means a delay in shop work, so that when last-minute, belated reports come in, we are put to it to know what to do. There have been occasions when very lengthy reports have arrived very near the time that we go to press, and thereby our schedule has been knocked into the proverbial cocked hat. While on the subject, it might be well to state that our deadline for regular material, such as scientific papers, news notes, et cetera, will have to be advanced; too many of our contributors have the notion that "along about the twentieth of the month" is the proper time to submit material, when as a matter of fact it would help a lot of we had all material exactly one month in advance. THE JOURNAL staff would very much appreciate your cooperation in this matter.

Shortly after our return from that Canadian jaunt we received a letter from the camp owner stating that the "Shir-Dot," that being the name of the boat that carries guests some forty-five miles up the water to the camp, had met with quite an accident on its return trip after taking us into town, and had to tie up over night, passengers and all. Then by dint of emergency repairs it had managed to creep home late the next morning. Some two days later the boat house at the "upper dam" had been struck by lightning, several outboard motors and various other articles of fishing equipment being lost. The letter intimates that some of our party may have been saboteurs.

As we frequently have remarked, *THE JOURNAL* is in no sense a political agency, nor does it discuss political matters in a general way. However, in times like these, when our profession is being sorely assailed by a group which seeks the complete demoralization of the medical program for the country, we feel that we have the right to speak out when occasion arises. At the recent meeting of Republican governors, in St. Louis, some twenty-six being in attendance, the following action was taken:

"The governors hit at the Wagner-Murray Bill to provide medical care for the population generally with a federal subsidy. In the report on social welfare, education and public health they made these recommendations:

- "1. There should be no political control of the profession of medicine.
- "2. States and local communities should improve their existing hospitalization, clinical treatment, visiting nursing and other public health programs as far as their resources permit.
- "3. The existing scattered federal agencies concerned with various aspects of the public health should be more closely integrated."

We quote two extracts from the *Washington Letter*, a publication sent out from the Washington office of The United Public Health League. It will be remembered that this league is composed of six western states, and that on March first they established a Washington office, with Ben H. Read temporarily in charge. Later Mr. Read returned to the California office, leaving James J. Boyle in charge in Washington. The league sends out a letter regularly, commenting on the goings-on in the national capital, matters that concern the medical profession. The extracts follow:

"*The Washington Times-Herald* recently commented editorially as follows: 'Mr. Roosevelt plans for his Fourth Term the regimenting of medicine so that doctors will be reduced to the dead level of white-coated bureaucracy. Their private offices are to fade out in favor of Government-dominated clinics, service stations where the patient pulls in for a set of routine passes guaranteeing him another 5,000 miles on the same set of tires.'

Another quotation from the letter:

"Archbishop Curley, of Baltimore, to a graduating class of nurses said, 'God help the nation if socialized medicine becomes the law of the land.'"

Even the stress of wartime does not stop the activities of publishers of "self-praise" books, books which will print, for a consideration, a lot of nice things about you. These outfits are purely commercial, and their product has no merit whatsoever. Of late hundreds of Indiana physicians have received letters from "WHO IS IMPORTANT IN MEDICINE?"—a veritable "Who's Who," but limited to the medical profession. It has been said that "this publication is about as exclusive as the *Directory* of the American Medical Association." Better invest that amount of money in a War Bond—it will pay much better dividends.

It seems that most people "like their doctor," according to a survey recently made, some 66 per cent of those interviewed having so expressed themselves. Most of the remaining 34 per cent had nothing to say, although a few did go so far as to be a bit critical. Our opinion is that, by and large, most folk who have a family doctor stick to that particular man because they like him, which means they have found him to be competent, understanding, and to have acquired an intimate knowledge of the "ins and outs" of members of their family. We refuse to be too much concerned about the subject, being of the opinion that if we are let alone we will continue to make a pretty fair job of attending to the physical and mental ills of the inhabitants of this country.

The Council on Hospitals and Medical Education of the American Medical Association makes a most dire prediction regarding the shortage of physicians in the next few years. They have published the statement that by 1948 there will be a shortage of physicians in this country that will amount to the staggering total of fifteen thousand. This is, of course, due to the ruling of Selective Service officials, *et al.*, regarding deferments of those young men planning to enter the study of medicine. General Hershey, in a letter to an Illinois senator, opines that such a shortage will not be necessary, that there will be enough physically-disqualified men, together with large numbers of young women, to make up this deficit. Also, that men over thirty years of age will be available as medical students. We have an answer to both these proposals. Regarding physically-disqualified men, it should be borne in mind that the practice of medicine is no easy task; it requires a strong physical and mental state to carry on the work properly. As to men over thirty, it should be borne in mind that it requires many years of study, plus a hospital internship ere one is fitted for the practice of the healing art, and the man over thirty years of age will find that he is getting rather old by the time he has completed his medical course. The whole problem seems to be a "mess," and should be studied by every physician. We recommend that the full report of the Council be carefully read, as it appears in *The Journal of the American Medical Association* for August twelfth.



President's Page



When more than a third of our number went away to war, they left with us the burden of caring for their patients. This is a heavy task and has added many hours to the working day of every one of us. They also left with us the responsibility of maintaining the freedom of the practice of medicine. This, too, has been a heavy task, because the present scarcity of doctors has given the forces of socialized medicine a golden opportunity to press their claims.

At first it seemed doubtful whether we could survive, but two years of war have given us time to get our second wind, and we begin to have much brighter hopes for the future. Unless the war is prolonged far beyond what now seems probable, there will not be a serious lack of medical services in Indiana, and the threat of socialized medicine now seems more remote than it did a year ago.

The peril through which we are passing has brought home to every doctor the knowledge that there are many weak spots in the present system of medical practice. Many of these weak spots are the result of our own actions, and they can and must be corrected. We must not lose sight of the fact that ours is one of the learned professions, engaged in the humanitarian task of treating and of preventing disease. As such, we have now and may always expect the good will and respect of our patients and friends, who constitute the public. When we cease to conduct ourselves as members of a profession, we may expect to lose the good will of the people.

The most encouraging thing about the outlook in Indiana is the splendid cooperation of every member of the State Association in trying to find a solution to our problems. Those called upon for work on the various committees have responded promptly and wholeheartedly, and there has been very little absenteeism. The last House of Delegates formulated a positive program for this year, and this has greatly facilitated the work of the officers and the committees. This is as it should be, for the House of Delegates is the legislative body of the Association and is the place where all questions are finally disposed of.

Next month we are to meet again. This meeting will be the most important that has been held for many years. The actions of the present House of Delegates may determine the future of medical practice, and may vitally affect the life of every doctor in Indiana. The many committee reports in this issue are of so much importance that they should be studied by every member of the Association. Those who can not attend the state meeting should see to it that their delegate is made acquainted with their views on the questions that will be up for discussion.

It would seem unnecessary to urge upon the delegates their duty to be present. Not only should every duly-elected delegate be present, but he should be alive and vocal enough to express the wishes of his county society. It is the duty of the delegates to deal positively and finally with every committee report, and to chart the course which the Indiana State Medical Association is to pursue for the next year.



EXECUTIVE COMMITTEE APPROVES GROUP MALPRACTICE INSURANCE

DON C. HAWKINS

Executive Field Representative, St. Paul Mercury Indemnity Company
CHICAGO

Sound medical defense through insurance is a serious problem requiring careful consideration on the part of any physician, and after a thorough study the Executive Committee of the Indiana State Medical Association recommends the St. Paul Mercury Indemnity Company as the vehicle through which this job of writing group malpractice protection for the doctors of Indiana is to be performed.

The St. Paul Mercury Indemnity Company is owned, operated, and controlled by the St. Paul Fire and Marine Insurance Company, which today is one of the really great American companies, having been organized in 1853 when the Northwest was still Indian country. This company has passed through many tragic events in its history, two of which

were the San Francisco earthquake and the great Chicago fire of 1871, which was possible only with the unbounded foresight and nerve of its directors and stockholders.

Shortly after World War I voluntary hospitals in many states found themselves in a rather difficult position inasmuch as the courts held that they were no longer immune to suits by members of the general public for damages suffered on account of malpractice, accidents, negligence and similar happenings on hospital property.

HOSPITALS REDUCE CHANCES OF LOSS

This trend was of great significance, and hospitals immediately took steps to meet it. Every effort was made to reduce the possibilities of loss through careful selection of the medical staff and careful selection and supervision of hospital personnel. In addition, of course, the most obvious protection to the hospital was the provision for adequate insurance against all forms of public liability for which they were likely to be held accountable.

Directors of hospitals are entrusted with funds provided by the public for hospital purposes, and if the courts were no longer going to protect these funds through exempting hospitals from the types of liability commonly borne by other activities, then the trustees should protect the funds in every way they can.

In certain communities, in addition to the increasing

strictness of the courts, there has been difficulty because of racketeering in damage suits, and in more than one city indictments were returned against a group of lawyers, doctors, and runners for their ambulance-chasing activities.

The St. Paul Mercury Indemnity Company, in co-operation with the Insurance Committee of the American

RECOMMENDS BASIC GROUP POLICY

The St. Paul Mercury Indemnity Company, which has been officially designated as the underwriter for group malpractice insurance by your committee, is owned and operated by the St. Paul Fire and Marine Insurance Company, one of the largest in its field. The selection of this company was made in accordance with the instructions from the House of Delegates last year that such arrangements be made with an insurance company. Your committee has spent much time and effort in arriving at its decision in recommending this company to you. Letters were sent to each insurance company, asking whether or not it would be interested in writing this type of insurance. Several widely-known companies said they were not interested in submitting a group policy. However, four well-established companies replied that they would be interested. Conferences then were held with each of these companies with the result that your committee recommends the St. Paul Mercury Indemnity Insurance Company as offering the type of basic group policy which best suits the purpose of the physicians of Indiana. Mr. Don Hawkins, of Chicago, the author of the accompanying article, has engineered surveys of many hospitals, which have resulted in lessened risks. Mr. Hawkins has a thorough understanding of malpractice insurance problems. Members serving in the armed forces will be insured at half rate.

EXECUTIVE COMMITTEE,
Indiana State Medical Association.

Hospital Association, the American College of Surgeons, and insurance committees of state associations conducted a study over a period of several months, and as an outgrowth of this study were able to provide a program which to a considerable degree overcame all of the objections of previous programs and forms of insurance existing at that time.

BROAD COVERAGE ASSURED

Inasmuch as the individual doctor has a definite responsibility in the successful operation of a hospital, this program was extended to include members of the staff, and individual policies were issued under a similar broad form to cover them in their private practice wherever they were licensed to practice, and irrespective of the nature of their practice.

The program of group protection which is proposed for the members of the Indiana State Medical Association in a sense is a miniature of the program which was established for the hospitals and

adopted by them throughout the United States. In addition to the fact that your Association will have a close connection direct with the insurance company, the contracts themselves will be negotiated with the company's agent living in your community, paying taxes for the maintenance of his property and institutions, and certainly a man in this position is going to give a great deal of thought and consideration to the entire program from all angles.

The Executive Committee of the Indiana State Medical Association is approaching the problem fundamentally on a state-wide scale, and information will continue to be gathered which should be beneficial to each member of the organization. You will be assured that your responsibility for losses

are fully protected by proper forms of insurance properly written. There are many advantages in the development of a plan of this character, and it is hoped that there will be a substantial reduction in the losses and other expenses, which will be passed on to the individual members when it is actuarially sound to do so.

The further development of the plan will progress as rapidly as the individual members signify their willingness to cooperate.

For any additional information you may desire, communicate with the branch office of the St. Paul Mercury Indemnity Company, 1126 Circle Tower, Indianapolis, Indiana.

* * * *

LETTER INFORMS MEMBERS

The following letter has been sent to all members of the Indiana State Medical Association, informing them of the recommendation of the Executive Committee of the Indiana State Medical Association in regard to group malpractice insurance:

September 1, 1944.

Dear Doctor:

Your Executive Committee, after considerable thought and study on the problem, is happy to announce that arrangements have been completed with the St. Paul Mercury Indemnity Company to provide malpractice coverage in the form of a group policy for the members of our association, effective at once. Detailed announcements concerning this appear in the September issue of *THE JOURNAL*.

The St. Paul Mercury is an unusually strong insurance company with ample experience in the medical and hospital field, with local representation in practically every community of our state.

The contract of insurance which is proposed for the members of the association is exceptionally broad and will provide adequate protection for our members against claims arising as the result of their practice, irrespective of the nature of their practice, at a cost which is fair. Other details which influenced the selection of this company, such as (a) a voice in the governing of premium cost, and (b) selection of legal counsel for the defense of claims, are available at the headquarters' office of the Indiana State Medical Association.

Your committee feels that strong and positive action must be taken to unite all available defense

elements into a solid front. We feel that we have met our objective in the following way:

1. To relieve the state association of some part of its malpractice defense costs in order that we might continue our other services without increasing the defense appropriation.
2. To prevent, if possible, a heavy increase in the cost of malpractice insurance rates for individuals; and, if experience under the group defense arrangement justifies it, to obtain ultimately a reduction in the cost of malpractice insurance.
3. To preserve for all members those excellent and highly necessary principles of defense that the association, through its legal counsel, has so painstakingly established.

We need the support of each member in order that we may receive the benefits of this plan.

Yours sincerely,

EXECUTIVE COMMITTEE.

C. A. NAFE, M.D., *Chairman*,

C. H. McCASKEY, M.D.,

J. T. OLIPHANT, M.D.,

N. K. FORSTER, M.D.,

F. T. ROMBERGER, M.D.

FOR LIST OF INSTRUCTIONAL COURSES OFFERED AT THE
ANNUAL MEETING OF THE INDIANA STATE MEDICAL ASSOCIATION

See page 479

THE ROLE OF THE PHYSICIAN IN BLUE CROSS

GUY W. SPRING

Executive Director, Mutual Hospital Insurance, Inc.

INDIANAPOLIS

A Blue Cross hospital service plan has been organized under the sponsorship of the Indiana Hospital Association and is now in operation. Its corporate name is "Mutual Hospital Insurance, Inc.," and it is located at 801 Underwriters' Building, 445 North Pennsylvania Street, Indianapolis.

Non-profit Blue Cross Plans to provide prepaid hospital care to employed people and their families on a group basis are now in operation in practically every state in the nation. The fact that the Indiana Plan was among the last to be organized has many advantages. Among these are the following:

1. The organization serves the entire State of Indiana. Many states readily enacted legislation making possible the establishment of non-profit hospital service plans to serve single communities, counties, or groups of counties, not realizing that a state-wide organization could best serve the community interests of the state.

In the absence of such enabling legislation in Indiana, it was necessary to organize the Blue Cross Plan under the mutual insurance laws of the state, hence, the name "Mutual Hospital Insurance, Inc."

2. The Indiana organization is in a position to profit by the mistakes that have been made by other plans during the past several years.

3. The idea of a group hospital plan has been more readily accepted by the medical profession here than in many areas where earlier plans were introduced. The basic principle of Blue Cross—that of providing prepaid hospital service to employed people and their families on a voluntary basis, as opposed to a compulsory plan under the auspices of a paternalistic government—has become apparent to them as a step away from rather than toward the principle of socialized medicine.

4. The experience of other plans has pointed the way to a most equitable and satisfactory method of compensating the hospitals for the services provided to Blue Cross members.

5. The actuarial experience that has been recorded by other plans has made it possible for the Indiana Plan to develop one of the most comprehensive and all-inclusive membership certificates yet to be offered by any Blue Cross Plan.

6. The widespread publicity which has been generated by the seventy-seven plans which preceded the Indiana Plan, and the favorable reaction of some 15,000,000 people now enrolled in Blue Cross Plans, has filtered into Indiana and will greatly assist in the educational and enrollment programs.

Although Mutual Hospital Insurance, Inc., was not incorporated until late in May, most of the organization detail and its attendant red tape is behind us, and it is expected that membership certificates in groups that have already signified their intention of enrolling their people will be made effective late in August or early in September. The credit for this unusual speed goes to the Indiana Hospital Association and the Indiana State Medical Association for their understanding and cooperation. The degree of success which the organization will enjoy will be in direct proportion to the degree in which this cooperation is continued.

Since a substantial percentage of the population of the state will eventually be embraced in the membership of the Blue Cross Plan, the doctors throughout the state will want to understand the provisions of the membership certificate, and be in a position to interpret it to their patients.

The membership certificate states that the member must be admitted to a hospital upon the recommendation or authorization of his own physician before he is entitled to service. That the success or failure of the plan is largely in the hands of the doctors, therefore, becomes apparent.

The plan was designed to provide care to members who require bed and nursing care for acute conditions. It was not designed for the convenience of members for rest cures, for diagnostic purposes alone, or services of a nature which under ordinary conditions would be performed by the physician or surgeon at his office or at the member's home.

SERVICES PROVIDED

When a member of Blue Cross, or an eligible member of his family, is admitted to a participating hospital as a bed patient upon recommendation or authorization of the attending physician or surgeon, hospitalization consisting of the following services will be provided and paid for in full, unless specifically limited, when such services are rendered in the hospital and are a part of and in conjunction with treatment of the illness or condition for which the member or dependent was hospitalized:

Hospital Accommodations

1. Bed (in standard or ward room as designated in the member's application).
2. Meals, including special diets.
3. General nursing service.
4. Operating room and delivery room service.

5. Drugs used in the hospitals and listed in the United States *Pharmacopoeia*, the *National Formulary*, *New and Non-Official Remedies and Biologicals and Solutions*.
6. Dressings and plaster casts.
7. Oxygen therapy.

Professional Services

1. X-rays, up to \$15.00 per admission.
2. Anesthesia, up to \$10.00 per admission.
3. Laboratory service.
4. Pathological service.
5. Electrocardiograms.
6. Basal metabolism tests.
7. Physical therapy.

Few Blue Cross membership certificates differentiate between hospital services and professional services which are rendered by specialists within the hospital. This division and careful identification of the professional services was made at the request of the doctors themselves precedent to the inclusion of these services in the membership certificate.

This division is made clear in all of the literature of the Blue Cross Plan, and thousands of people

in the State of Indiana will learn for the first time that such services as radiology and pathology are professional rather than hospital services. The people, generally speaking, believe that such services are hospital services by reason of the fact that charges for these services have always appeared on hospital bills without segregation. Thus, the inclusion of these services in the membership certificate is a step toward the preservation of the professional prerogatives of physicians in the specialty groups.

The membership certificate further stipulates that if and when a medical service plan is organized by the Indiana State Medical Association, the services designated as professional services will be withdrawn from the hospital service certificate and included in the services to be provided by the medical plan.

Every effort has been made in the development of the membership certificate to emphasize the importance of the confidential relationship between the physician and his patients. We are confident, therefore, that the physicians will assist in the maintenance of a pleasant relationship between the members, the plan, and the hospitals.

NEW PROVISIONS FOR 1944 FEDERAL INDIVIDUAL INCOME TAX RETURNS

WILL H. SMITH

Collector of Internal Revenue, Treasury Department

INDIANAPOLIS

Two new Revenue Acts have become laws since January 1, 1944. The Revenue Act of 1943 which became law February 25, 1944, over presidential veto, and the Individual Income Tax Act of 1944 approved May 29, 1944. The two laws must be taken into consideration in determining the 1944 tax liability. Certain provisions of the Revenue Act of 1943 have been superseded and will not become effective. Major items of the 1943 Act which still remain a part of the basic law are as follows:

- (1) No credit for earned income.
- (2) No deduction for Federal Excise Tax.
- (3) Exclusion of mustering-out pay for military and naval personnel.
- (4) Exclusion of cost-of-living allowances paid to civilian officers and employees of the Government stationed outside the continental United States.
- (5) A \$500.00 special deduction for blind individuals.
- (6) Special treatment of back-pay attributable to prior years.

The primary purpose of the Individual Income Tax Act of 1944 is to simplify the filing of federal

income tax returns of individuals. There is no great change in the number of taxpayers or in the amount of revenue to be collected. The outline below is of major changes effective by the enactment of the Individual Income Tax Act of 1944.

(1)

The Law includes a new term, "adjusted gross income," which must be given consideration. The "adjusted gross income" means the gross income minus—

- (a) Trade and business deductions.
- (b) Expense of travel and lodging in connection with employment.
- (c) Reimbursed expenses in connection with employment.
- (d) Deductions attributable to rents and royalties.
- (e) Certain deductions of life tenants and income beneficiaries of property.
- (f) Losses from sales or exchange of property.

"Adjusted gross income" is used primarily in connection with the optional tax form which is based on the "adjusted gross income." This form,

similar to the 1943 Form 1040A, may be used by individuals with an "adjusted gross income" of under \$5,000.00. "Adjusted gross income" is also taken into consideration in limiting charitable deductions and also in the limitation of the medical expense deduction. This new provision will permit many individuals originally precluded from filing on Form 1040A to file on the optional form and pay the tax according to the optional table. Optional tax becomes applicable to "adjusted gross incomes" regardless of source of income.

(2)

Surtax rates:

<i>Surtax Net Income</i>	<i>Rate</i>
\$ 0 to \$2,000	20%
2,000 to 4,000	22%
4,000 to 6,000	26%
6,000 to 8,000	30%
8,000 to 10,000	34%

And so on up to 91 per cent on excess of over \$200,000.00.

(3)

Normal tax is at the rate of 3 per cent and takes over certain aspects of the old Victory tax.

(4)

Victory tax is repealed.

(5)

An optional standard deduction may be claimed in lieu of non-business deductions.

(6)

Earnings of minor children need no longer be included in the Federal Income tax return of the parents.

(7)

In lieu of the old personal exemption, certain credits are allowed against surtax known as surtax exemptions. For surtax purposes each person has a surtax exemption of \$500.00, \$500.00 for his spouse, and \$500.00 for each dependent. The surtax exemption is not allowed for the spouse, however, (except on joint returns) unless the spouse has no gross income and is not a dependent of anyone else.

(8)

For normal tax purpose, a \$500.00 exemption is allowed as a credit against net income. On a joint return the exemption allowable is \$1,000.00 unless the "adjusted gross income" of one spouse is less than \$500.00. In that case the normal tax exemption is \$500.00, plus the "adjusted gross income" of the other spouse.

(9)

Head of family status is eliminated.

(10)

"Dependent" means any of the following persons over half of whose support, for the calendar year in which the taxable year of the taxpayer begins, was received from the taxpayer:

Children, grandchildren, great-grandchildren, et cetera.

Stepchildren (but not their children).

Brothers and sisters.

Step-brothers and sisters.

Half-brothers and sisters.

Parents, grandparents, great-grandparents, et cetera.

Step-father or step-mother (but not their parents).

Nephews and nieces.

Uncles and aunts.

"In-laws"—son, daughter, father, mother, brother, or sister.

A cousin is not considered closely connected by blood relationship and, therefore, not a dependent for Federal Income Tax purpose. The factors in determining dependency status are whether or not the major support of the individual has been contributed by the taxpayer, and that the claimed dependent has less than \$500.00 gross income during the year, and that the claimed dependent is closely related.

(11)

Marital Status is determined as of the last day of the taxable year.

(12)

Every individual with a gross income of \$500.00 or more is required to file a return.

(13)

Individuals whose only income is from salary or wages and under \$5,000.00 may elect to file a statement and have the collector compute the tax from the optional table. In cases where the collector computes the tax, the additional amount due must be paid within thirty days from the mailing of a notice and demand.

(14)

Charitable contributions are limited to 15 per cent of the "adjusted gross income" instead of 15 per cent of the net income, as under the prior law, with the result that the maximum deduction is increased.

(15)

The allowable medical expense deduction is determined by that amount which exceeds 5 per cent of the "adjusted gross income" computed without medical expense deduction. This usually results in a smaller deduction than under the prior law which took into consideration net income.

(16)

Joint returns are allowable although one spouse has neither gross income nor deductions. It is not necessary that the husband and wife be living together in order to qualify to file a joint return. The status as husband and wife is determined as of the last day of the taxable year. Individuals who are divorced during the year may not file joint returns with their former spouses. No joint return may be filed if either spouse is a nonresident alien

or if the husband and wife have different taxable years. If one spouse dies during the year, a joint return may not be filed.

There are also major amendments with respect to the filing of Form 1040-ES, Return of Estimated Income Tax.

Individuals required to file:

(1) An individual whose gross income from wages subject to withholding can reasonably be expected to exceed the sum of \$5,000.00, plus \$500.00 with respect to each surtax exemption (except his own).

(2) An individual whose gross income from sources other than wages subject to withholding can reasonably be expected to exceed \$100.00 for the taxable year, and his gross income to be \$500.00 or more.

Time for filing:

A declaration, if required, shall be filed on or before March 15th of the taxable year except that if the requirements are first met

- (a) after March 1 and before June 2 of the taxable year, the declaration shall be filed on or before June 15 of the taxable year, or
- (b) after June 1 and before September 2 of the taxable year, the declaration shall be filed on or before September 15 of the taxable year, or
- (c) after September 1 of the taxable year, the declaration shall be filed on or before January 15 of the succeeding taxable year.

An individual may make an amendment of his declaration filed during the taxable year on or before the fifteenth day of the last month of any quarter of the taxable year subsequent to that in which the declaration was filed and in which no

previous amendment has been filed, except that in the case of an amendment filed after September 15 of the taxable year it may be filed on or before January 15 of the succeeding taxable year. If on or before January 15 of the succeeding taxable year the taxpayer files his regular annual return for the taxable year for which the declaration is required and pays in full the amount computed on the return as payable, the return filed will operate as a declaration or amendment to the declaration. This provision will first apply to the return for the year 1944 tax. In the case of an individual whose estimated gross income from farming for the taxable year is at least two-thirds of the total estimated gross income from all sources for the taxable year, he may postpone the filing of a declaration until January 15 of the succeeding taxable year. Under the prior law a taxpayer was not qualified to file an estimation of income on the basis of a farmer unless 80 per cent of his estimated gross income was from farming.

The new law changes the withholding rates. New Government tables for the withholding rates will be provided. Changes in withholding will apply only to wages paid on or after January 1, 1945. New withholding exemption certificates are required to be filed by all employees by December 1, 1944. With the exception of the changes in withholding and in the provisions setting forth the requirements of individuals required to file declaratory statements of estimated income, the Individual Income Tax Act of 1944 is effective for 1944 tax computations and is applicable to taxable years beginning after December 31, 1943. The change in requirements for filing declarations and the new withholding rates will not apply until January 1, 1945.

VOICE OF MEDICINE

SURGICAL REPORTS

June 26, 1944.

Dear Editor:

I would like to advocate the practice, to surgeons and hospitals, of giving a written report to all patients who have had surgery. While this idea is not new, it seems to me to have been more urgently needed during the past few years when so many doctors have been displaced and there has been such widespread travel on the part of patients.

Statements such as "a general housecleaning," when referring to pelvic operations, are neither enlightening nor scientific. In cases of malignancy, where it seems advisable not to inform the patient, some member of the immediate family should re-

ceive the report. These reports should be short and to the point, telling just what condition was found and what sort of procedure was used to correct the pathology. The patient should be admonished to keep this report for future reference, and it should be most helpful to both the patient and to any doctor in appraising future symptoms.

These facts have been clearly demonstrated in the past few years during which time I have been called upon to treat the wives of soldiers from all parts of the country. This could be done on a nation-wide basis and be a further public service on the part of the medical profession.

Sincerely yours,

W. L. PORTEUS, M.D.,

Franklin.



Military News



Captain Richard Gery, of Lafayette, is now stationed at Camp Stuart, Savannah, Georgia, on the surgery service of the station hospital. Incidentally, he recently received his captaincy.

Another Indiana physician having gone overseas recently is Captain Robert L. Fullerton, of Indianapolis, who left Camp Ellis, Illinois, for a New York A.P.O. destination.

Announcement has been made of the promotion of Dr. Farrol A. Dragoo, of Middletown, to the rank of major. He is head physician of an Air Depot Group at Tinker Field, Oklahoma City, Oklahoma.

Lieutenant Colonel R. J. McQuiston, of Indianapolis, is serving as chief of the EENT Section of the AAF Regional Station Hospital, at Chanute Field, Illinois.

Dr. H. E. Hill, of Muncie, has been promoted from major to lieutenant colonel. Colonel Hill is attached to the station hospital at Sioux Falls, South Dakota.

After approximately a year's service in Australia, Captain Wayne W. Houser, of Monon, has returned to the Fitzsimmons General Hospital, Denver, Colorado.

A change-of-address from Captain Marion M. Crum, of Angola, indicates that he has gone overseas, for it gives a New York, A.P.O. address. He was formerly stationed at Baer Field, Fort Wayne, Indiana.

Dr. Paul L. Long, of Anderson, has been stationed in the South Pacific for the past two years. He is now in the Russell Islands, and has recently been promoted from captain to major. Congratulations, Major Long!

Lieutenant Colonel Joseph S. Skobba, who has been chief of the neuropsychiatric service at the Lawson General Hospital, Atlanta, Georgia, has been assigned to duty with the headquarters of the Fourth Army at Fort Sam Houston, San Antonio, Texas, where he will serve as consultant in psychiatry. Colonel Skobba had been at the Lawson hospital since May, 1941.

After completing six weeks' training at Carlisle Barracks, Lieutenant H. F. Kennedy, of Indianapolis, has been transferred to the Replacement Center Hospital at Fort Bevens, Massachusetts.

Lieutenant Colonel J. E. Owen, of Indianapolis, is chief of surgery at the Valley Forge General Hospital, Phoenixville, Pennsylvania.

After a short leave following duty in Italy, Captain J. P. Marsh, of Blountsville, reported recently to the Army Air Force Replacement Center, at Miami, Florida.

According to a news release, Major William O. Baldrige, of Terre Haute, has been appointed commanding officer of the station hospital at Camp Anza, California. He has also been designated as camp surgeon.

Two Crawfordsville physicians are serving with American medical units in Italy. Major Fred N. Daugherty was transferred there a few weeks ago from Africa, and Lieutenant Colonel Hawthorne C. Wallace arrived in April, after serving at Camp Breckenridge, Kentucky. He is with an Evacuation Hospital Unit, which is believed to be caring for wounded French soldiers. Both Major Daugherty and Colonel Wallace are engaged, for the most part, in surgery.

"Medsoc" has received the following letter written by Lieutenant Jerome E. Holman, Jr., of Indianapolis: "I thank you kindly for the May letter written by Ernie Pyle. It was very refreshing. I am located somewhere in England and am enjoying myself to the fullest extent. We are billeted in private homes and therefore have excellent contact with the English people. They are very gracious, and as generous as war rationing permits."

Colonel E. C. Jones, of Fort Hayes, Ohio, is retiring as head of the Medical Department of the Fifth Service Command, Army Service Forces, embracing the states of Ohio, West Virginia, Kentucky and Indiana. For the past four years he has held this post, but has actually served in the Army Medical Corps for more than thirty-seven years. At one time he was an assistant to the Surgeon General of the Army, at Washington. He will be succeeded in the Fifth Service Command by Colonel Edgar A. Noyes, Army Medical Corps, a commanding officer of the Cushing General Hospital, Framingham, Massachusetts.

Dr. Irvin W. Wilkens, of Indianapolis, has been advanced to a major. He is stationed at Scott Field, Illinois.

Lieutenant Colonel Brice E. Fitzgerald, of Indianapolis, is on duty as flight surgeon in an Air Force Troop Carrier Command, based in England.

Another recent promotion is that of Dr. Richard N. Washburn, of Rensselaer, who has been advanced from major to lieutenant colonel. Colonel Washburn has served overseas for more than a year.

Lieutenant Commander Hugh A. Miller, a '37 graduate of the Indiana University School of Medicine, now has a San Francisco, Fleet post office address. Commander Miller has been stationed in New Guinea, but is now in Australia.

"THE JOURNAL is a good contact with civilian medicine," says Major Charles N. Manley, of Rising Sun. He further states, "I haven't seen an operation or delivery in three years and five months. It is plenty hot here in New Guinea, but health generally is very good."

In a recent V-Mail letter, Captain Otto F. Lehmberg, of Columbia City, says: "Time goes by so fast that one can hardly realize that a year-and-a-half has passed since leaving the 'land of the free.' Six months in Africa, seven in Sicily, and now Italy; and then, who knows? Keep the home fires burning!"

Lieutenant Commander Philip T. Holland, of Bloomington, who entered the service on June 21, 1942, and after serving first at the U. S. Naval Hospital at Great Lakes and later at the Naval District Headquarters at Seattle, and then assigned to sea duty, says, "It is mighty fine to be reunited with my family and back in the States once more." After twenty months of service aboard the *U.S.S. Mississippi*, Commander Holland reported for duty at Great Lakes on July fourth. He was assigned to the Surgical Division at the hospital.

"Greetings and felicitations to everyone at home," writes Captain Joseph L. West, of Indianapolis. He continues, "I am now in 'Merrie Old England,' enjoying the best of health, and expect to be quite busy in the very near future. The beer is warm and the Scotch is scarce, but otherwise everything is okay. Plenty of good food and pleasant quarters. The people are friendly and hospitable, and for short distances the bicycle is a fair substitute for the automobile. Saw Lacey Shuler yesterday, and expect to see him frequently. He has been pretty busy playing bridge with his colonel."

Lieutenant Frank W. Oliphant, of Mount Vernon, had the good fortune of being able to visit many points of interest in Rome, even seeing the Pope. He reported that the Vatican City had suffered little damage.

Major Daniel Stiver, of South Bend, has returned from Iran, and has been assigned to the Gardiner General Hospital at Chicago. He is doing surgery there.

Stationed aboard a hospital ship anchored off Saipan, Lieutenant Commander Albert F. Clements, of Evansville, aided in caring for the wounded of that battle. Commander Clements has been assigned to the ship for the past year, and is head of the eye and ear clinic.

Major Raymond R. Calvert, of West Lafayette, who entered the army two years ago, has been executive officer at Selfridge Field, Michigan, and was recently assigned to new duty as base surgeon on June first. At the present time Major Calvert is taking the flight surgeon course at the School for Aviation Medicine, at Randolph Field, Texas. On completion of the course he will return to Selfridge Field to assume his new duties.

From Normandy comes a letter written by Captain Martin D. Garfield, of Hobart. He says: "This is the second stop in my European tour, having been in England for the few pre-invasion months. We had a little trouble trying to land on June sixth, but finally got ashore on the morning of June seventh. If there weren't such things as censors I could write a book on subsequent events."

The following is an excerpt from a recent news release sent by the United States War Department to the *Lafayette Journal-Courier* and published in its July 22, 1944, issue:

"For the past eighteen months, Captain Floyd T. Romberger, Jr., has been stationed along the Ledo Road which snakes its way through the mountainous jungles of Assam, India, into northern Burma.

"During the past many wounded men in war have needlessly died for want of prompt medical attention in this outpost, but due to the resourcefulness of Captain Romberger, air clearing stations were set up back of the front lines. C-47 transport planes bring the wounded men to these clearing stations, and here they are separated, depending on their injury, and sent by ambulance to a hospital where a competent American medical staff takes over. Thus, in an incredibly short time a man may go from a slit trench to surgery. The development of these clearing stations was more or less unscheduled, but through their development many wounded men have cause for greater hope for the future."

Dr. E. Paul Tischer, of Indianapolis, has been promoted to a major. Major Tischer is at present stationed in Champaign, Illinois.

Captain John M. Young, of Indianapolis, has been transferred to Brooks Field, Texas. He had been stationed at the Gardiner General Hospital, at Chicago.

Lieutenant Colonel Don J. Wolfram, of Indianapolis, is now attached to the Surgeon General's Office in Washington, D.C. He formerly was at New Orleans.

Captain Elmer S. Zweig, of Fort Wayne, is serving as surgeon with a hospital corps which is attached to an air force service command somewhere in England.

Major William W. Washburn, of Lafayette, who has served three-and-a-half years as flight surgeon, and who landed in Port Lyauty with the original invasion of North Africa, is now stationed in Corsica.

Following is a most interesting letter from Major Merle E. Whitlock, of Mishawaka, which we have taken the liberty of reprinting from the *St. Joseph County Service Bulletin*:

"After some ten days in a combat zone, I submit that General Sherman's evaluation of war is a gross understatement. It isn't too bad on me, but I am thinking of my clientele. However, our unit has been quite fortunate with only one death in our hospital—a perforating head injury. Ninety or ninety-five per cent of our cases are wounds of the extremities or non-penetrating shell wounds of the trunk. An enormous amount of plaster is used, even on soft tissue wounds, to render transport more comfortable and dressings more secure. Only the more serious cases stay with us more than twenty-four hours; these include the chests and bellies and the bad compound fractures. While no spot on this relatively small area of France is immune from enemy action, our location about twelve miles behind the front has been rather safe, although we have found ourselves uncomfortably near the landing zone on the beach one or two nights. But enemy night attacks are steadily diminishing. Anyway, after twelve or fifteen hours in a surgery it takes quite a bit to disturb one's sleep. No complaints about inactivity now. I have done all the bellies and most of the chests that have come to us. Some of them have been both tough and interesting and a far cry from civilian surgery. Blood and plasma and penicillin are abundant, all of which serves to explain the favorable termination of our cases. God knows how different it would be without the first two, at least. Yesterday we stooped admitting patients in preparation for a move. I had a jeep ride up on the Cherbourg peninsula to see a fellow who was formerly with our unit. He is connected with a clearing company which evacuates by air and water to England. While there I acquired a pair of the coveted paratrooper boots. Of course, they were slightly used but the owner won't need them any more. For the last few days about half of our admissions were prisoners. Most of them are in their teens, thoroughly fed up with war, and admittedly convinced that Germany is all washed up. One had recently tried to find his home in Hamburg; he said that four-fifths of the town is in absolute ruins. These prisoners can't see any use in Germany continuing to fight. Personally, I think their notion a good one."

Captain Joseph P. Worley, of Indianapolis, is now serving with the Army Medical Corps in India.

Lieutenant Karl C. Randall II, of Lafayette, was promoted to a lieutenant commander and has just returned to the United States after a tour of duty of about two years with a Marine Division in the South Pacific. Lieutenant Commander Randall is now stationed at El Toro Field, Santa Ana, California.

After eighteen months of foreign duty, Major Daniel H. McKinney, of Lafayette, who was commanding officer of a station hospital in Iran, returned to the United States and enjoyed a three weeks' leave with his family. Major McKinney made a trip around the world; he arrived at Iran by boat, being on the water eighty-nine days, and the trip from Iran to the United States was made by air, arriving in New York about five days after leaving Iran.

The horror of war is clearly portrayed in the following letter received from one of our members stationed somewhere in France, who is wondering if all the folks back home and those in the service who are engaged in restoring individuals back to health are thinking of those who are engaged in the most dangerous of all tasks—evacuating the maimed and mutilated under shellfire. "Giving the life-saving plasma, sulfanilamide, tetanus, et cetera, under trees, after dark, and in mud, with mortar shells and machine gun bullets zipping over one's head. Ducking in and out of holes when it is too hot—sending boys out to pick them up even farther ahead—out to possible death themselves, sending men back completely out of their heads from shock and blast—nervous wrecks! Getting calls from wounded men up in the lines where it is impossible to evacuate them until after dark or not until the next day. Think of all that worry and anxiety! To have a tank blown up in a mine field (in which later six vehicles blew up) and to have a tank commander say that if we didn't get a man out of it, he would do so himself. One of my boys went up at 11:30 at night in a jeep to get him, with Germans talking all around! He gets a medal for that. They should all have medals—aid men, litter bearers—everyone of them, bless them! and I'll get them for them.

"Think, gentlemen, the men all swear by the medics—the aid men, litter bearers—and us, the chosen few—the battalion surgeons—whose job by far is the hardest of any in the Army or Navy. Give us credit by all means, and I sincerely hope you never are put in such a position, for it takes a man of men to handle such a job.

"Here's hoping I'll see you all some day (sometimes I doubt it) and if you want to hear some real stories, look me up from three to five hundred yards behind the lines."

POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of September, 1919)

"War Wounds of the Abdomen," by H. O. Bruggemann, of Fort Wayne; "Report of a Case of Appendiceal Abscess Discharging Through the Vagina in a Girl of Nine Years," by Miles F. Porter, Sr., of Fort Wayne; "Foreign Bodies in the Bladder and the Cystoscope as an Aid in their Removal," by W. N. Wishard, of Indianapolis, and "Lobectomy vs. Ligation of the Vessels in Toxic Goiter," by Thomas B. Noble, of Indianapolis, comprised the scientific section of this number.

* * *

This being the pre-convention number, several pages were used in presenting the "photo-gallery" of the official family. Several of these men have passed on, but many are still active in medical practice and in organization work.

* * *

Hotel rates were published, and it is noted that registrants could get good rooms for \$2.75 and \$3.00 if alone, and an additional charge of \$1.00 was to be made for each extra person in the room.

* * *

Dr. George W. Spohn, of Elkhart, chairman of the Credentials Committee, had published an announcement that delegates *had* to have credentials before they would be seated in the House. We recall the marked determination of Dr. Spohn in this matter. We also recall that as usual many delegates arrived without the important bits of paper and managed to take part in all the activities of the House just the same — even then as now!

* * *

The reports of committees occupied less than three Journal pages—now we have dozens of pages in each pre-convention number.

* * *

It was noted that the cash balance of the Indiana State Medical Association, as of September 1, 1919, was \$4,018.67. (At that time we were paying \$0.75 per member to the publisher of THE JOURNAL; now the allotment is \$2.00 per member.)

* * *

Editorially, the President, Dr. W. H. Stemm, North Vernon, was given a due meed of praise for his contribution to Indiana Medicine.

* * *

Some of the newer aspects of hyperthyroidism were discussed, as was a timely editorial by Dr. A. C. Kimberlin, of Indianapolis, on "Feeling the Pulse."

The editor advocated the raising of medical fee bills throughout the state, also the raising of the standards of our hospitals.

* * *

Tribute was paid to Sir William Osler, who had recently celebrated his seventieth birthday.

* * *

A plea for a "return to the medical society," now that the war was over, was being made; returning members being urged to become active in their local groups at once.

* * *

Editorial notes were scarce in this issue, this being the period when the editor was wont to make his Lake-of-the-Woods fishing trip.

* * *

Dr. Charles E. Hansel, member of the South Bend Clinic, had dropped dead while on a local golf course.

* * *

Physicians returning from war service and re-establishing practice were: H. J. Thompson, LaPorte; W. M. Bigger, Hammond; E. L. Dewey, Whiting; Don Miller, Indianapolis; Weir Miley, Anderson; Fred Metts and J. L. Redding, both of Bluffton; T. L. Sullivan, Indianapolis; L. H. Segar, Indianapolis, and N. A. Cary, Crawfordsville.

* * *

Dr. Claude A. Robinson had opened an office at Frankfort, where he was to be associated with an uncle, Dr. John Robinson, of Geetingsville.

* * *

Richmond had been having an epidemic of diphtheria, fifty to one hundred cases having been reported.

* * *

Ten nurses were graduated from the Dr. W. B. Fletcher Sanitarium, Indianapolis; Dr. Jane M. Ketcham delivered the graduating address.

* * *

The Irene Byron Tuberculosis Hospital, Fort Wayne, was dedicated on August tenth, with rather elaborate ceremonies. Governor Goodrich, Dr. Victor C. Vaughan, of Ann Arbor, Dr. William F. King, and Doctor John N. Hurty were among the speakers.

* * *

The new medical school building was all but completed, and was to be ready for use on the opening date, September sixteenth.

News Notes

Dr. R. L. Kleindorfer, of Evansville, has been appointed as a member of the city-county board of health.

Dr. Clarke Rogers, of Indianapolis, was recently appointed as a member of the Indianapolis Board of Public Health. He succeeds Dr. A. F. Weyerbacher, whose resignation because of professional responsibilities was accepted with regret.

Dr. Robert L. Dilts and Miss Virginia Lewis, both of Indianapolis, were married July twenty-eighth in the Sweeney Chapel at Butler University. Dr. and Mrs. Dilts will live in Indianapolis, where Doctor Dilts is engaged in the practice of his profession.

We are pleased to report that Dr. Charles R. Bird, of Indianapolis, has recovered from his prolonged illness and is back on duty with the Procurement and Assignment Service, as well as his own practice.

Dr. David B. Sher, formerly of Edwardsburg, Michigan, has moved to Mishawaka, and has established an office there for the practice of medicine. Dr. Sher will also maintain an office in Edwardsburg for the remainder of the summer.

Dr. Fletcher C. Stewart, head of the Marine Hospital of Evansville, has exchanged positions with Dr. Donald Patrick, executive officer of the Staten Island, New York, Marine Hospital. Dr. Stewart holds the rank of senior surgeon in the United States Public Health Service.

Announcement has been made of the appointment of Dr. Stephen C. Bradley to the Terre Haute Board of Health. He is to succeed the late Dr. M. B. Van Cleave. Dr. Bradley will have the care and control of the contagious disease department, together with the city's immunization program.

Dr. John H. Hare, who has been acting superintendent of the Madison State Hospital for the past several months, has returned to Evansville to resume his duties as superintendent of the Evansville State Hospital, which is being rebuilt after having been destroyed by fire several months ago.

Dr. James H. Stygall, of Indianapolis, has been reappointed as Chairman of the National Council of Tuberculosis Committees, by Dr. Jay Arthur Myers, president of the American College of Chest Physicians.

After seventeen months of service in the South Pacific, Dr. Elsworth Klahr, of South Bend, has been retired. During that time he was in combat, and has had some hair-raising experiences. He has been practicing in South Bend since the first of July.

After serving four years as one of the five members of the Indiana State Board of Health, Dr. H. E. Metcalf, of Connersville, has been elected as its president. He will preside at the called meetings of the group. Dr. Metcalf will succeed Dr. Herman Baker, of Evansville.

MEETING OF THE AMERICAN CONGRESS OF PHYSICAL THERAPY

The American Congress of Physical Therapy will hold its twenty-third annual scientific and clinical session September 6, 7, 8 and 9, 1944, inclusive, at the Hotel Statler, Cleveland, Ohio. Rehabilitation is in the spotlight today and physical therapy plays an important part in this work. All sessions will be open to the members of the regular medical profession and their qualified aids. For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago 2, Illinois.

THE PHYSICIAN'S IMPORTANCE IN WAR AND PEACE

To memorialize the medical profession's "skill and courage and devotion beyond the call of duty" is the purpose of the new prize-contest recently announced by the American Physicians Art Association.

The contest is open to all physicians, both civilian and military, who are members of the American Physicians Art Association. The prizes are sufficiently important to attract some very fine art in all of the principal media, including oil, water color, sculpture, and photography.

For full details, write to the association's secretary, Dr. F. H. Redewill, Flood Building, San Francisco, California. Also pass this information on to your physician-artist friends, both civilian and military.

Deaths

FIRST ARMY FLIGHT NURSE TO GIVE HER LIFE IN THE PERFORMANCE OF DUTY IN WORLD WAR II

Second Lieutenant Ruth M. Gardiner. Army Nurse Corps, of Indianapolis, was instantly killed in a crash ten miles northwest of Naknek, Alaska, on July 27, 1943, while on a mission for the evacuation of patients by air transport. She was the first Army Flight Nurse to be killed in this war.



Lieutenant Ruth M. Gardiner
Army Nurse Corps

Born in Calgary, Canada, on May 20, 1914, she came to the United States at the age of three. She was educated in Indianapolis, and took her nurses training at the White Haven Sanitarium School of Nursing and the Philadelphia General Hospital, Pennsylvania.

Lieutenant Gardiner was commissioned a second lieutenant in the Army Nurse Corps on January 15, 1943, and graduated with the second class of flight nurses from the School of Air Evacuation, Bowman Field, Kentucky, the training base for nurses of the First Troop Carrier Command, on February 18, 1943. She left Bowman Field on April 22, 1943, for evacuation duty in the Alaskan theatre, where she served until her death.

Posthumous honor was accorded Lieutenant Gardiner when the Army's Chicago Beach Hospital was renamed the "Gardiner General Hospital" in her memory. This is the first time an Army hospital has been named for a nurse. A portrait of Lieutenant Gardiner, painted and presented by Mr. Edmund Giesbert, a Chicago artist, also was unveiled at the hospital dedication ceremonies on July 9, 1944.

George Grant McConnell, M.D., of Mooresville, died August eleventh at the age of seventy-eight. He was a graduate of the Rush Medical College in 1892. Doctor McConnell had retired a few years ago.

Jesse D. Price, M.D., of Michigan City, died July third after a short illness. He was seventy-two years of age. Doctor Price graduated from the Louisville Medical College in 1906, and had practiced for the past nineteen years in Michigan City. He was a member of the LaPorte County Medical Society, the Indiana State Medical Association, and the American Medical Association.

James H. Taylor, M.D., of Indianapolis, died July twenty-third at the age of ninety-one. He was a graduate of the Indiana Medical College, at Indianapolis, in 1878. Dr. Taylor was Professor Emeritus of Pediatrics at the Indiana University Medical Center. He was instrumental in organizing the Fresh Air Mission for Children, and had at one time served as its president. He was a member of the Indianapolis Medical Society, an honorary member of the Indiana State Medical Association, and a member of the American Medical Association.

Lieutenant Commander Martlin P. Smith, M.C., of Muncie, was killed in an automobile accident in North Africa, on July fifth. He was thirty-six years of age. Commander Smith was a graduate of the University of Pittsburgh School of Medicine, in 1933, and was certified by the American Board of Otolaryngology. He was a member of the Delaware-Blackford County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Francis Marion Williams, M.D., of Anderson, was killed instantly in a collision between his automobile and a Pennsylvania train on August eighteenth. He was fifty-seven years of age. He graduated from the Indiana University School of Medicine in 1918, and in addition to practicing his profession he served at one time as mayor of Anderson. Doctor Williams had four sons in service, two of whom are also physicians. He was a member of the Madison County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

July 16, 1944.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Present at luncheon meeting: Committee for the Study of Lay Activity in Medical Practice—W. D. Gatch, M.D., chairman; O. O. Alexander, M.D.; A. P. Hauss, M.D.; H. O. Mertz, M.D.; C. S. Black, M.D., and A. M. Mitchell, M.D.

State Board of Health—Thurman B Rice, M.D., acting secretary; E. M. VanBuskirk, M.D.; Ernest Rupel, M.D., and Henry C. Metcalf, M.D.

R. E. Jewett, M.D., Bureau of Maternal and Child-Health, State Board of Health.

Legislative Committee—N. M. Beatty, M.D., and J. William Wright, M.D., co-chairmen.

MEMBERSHIP REPORT

Number of members July 14, 1944.....	3,317*
Number of members July 14, 1943.....	3,096
Gain over last year.....	221
* Includes 935 in military service and 125 honorary members.	
Number of members Dec. 31, 1943.....	3,344

The statements of receipts and expenditures for April, May, and June for the association committees and for May and June for THE JOURNAL were approved.

Treasurer's Office

Dr. Weyerbacher made a report upon the receipts and expenditures for the six months ending June 30, 1944, and the anticipated income and expenditures for the remaining six months. He also made a report on the state medical societies which have raised dues and made assessments during the emergency. This report showed that many states have increased their dues or assessed their members to cover the deficit incurred by the loss of dues from members who have joined the armed forces.

The treasurer reported that \$3,000 worth of United States Treasury bonds in the Medical Defense Fund had been called, and that this money had been re-invested in Fifth War Loan Bonds.

Expansion of Office

Approval received from Procurement and Assignment Service for full-time stenographic help.

1944 Annual Session, Indianapolis.

October 3, 4 and 5, 1944

Scientific exhibit. Rental of two new transparency cases for x-ray films was approved by the committee.

Banquet speakers. As Roger Lee, M.D., Boston, president-elect of the American Medical Association, cannot be present, the committee authorized sending an invitation to James R. Bloss, M.D., Huntington, West Virginia, chairman of the Board of Trustees of the American Medical Association, to be a guest speaker at the dinner to represent the American Medical Association.

War Participation luncheon. Admiral McIntire and General Rankin have accepted. The committee approved the idea of having special tables for fraternity and class luncheons at the War Participation luncheon.

Committee was informed that all meetings, including the banquet and the War Participation luncheon, are to be held at the Murat Temple, and that sandwiches and soft drinks will be served Tuesday and Wednesday noon during the meetings.

Instructional courses. Number of courses are to be doubled this year. Courses in the charge of Dr. Marlow Manion and Dr. Gordon Batman.

Letter from the Office of Defense Transportation read by committee.

Badges. The committee approved badges similar to those used for last year's convention.

House of Delegates breakfast is to be held at the Caypool Hotel.

Executive Committee meeting is to be held on Monday, October 2, at the Columbia Club.

Council luncheon is to be held at the Murat Temple.

Certificate of Appreciation is to be presented to Dr. Carl McCaskey by Dr. Oliphant.

Reservations have been made for guests at:

Indianapolis Athletic Club	18 rooms
Columbia Club	5 double rooms

Word received from the secretary of the Warrick County Medical Society, saying that they cannot send a delegate to the annual session. The committee suggested that this word be sent to Dr. I. E. Barclay, councilor for the First District.

Legislative, Legal and Social Security Matters

National

Wagner-Murray-Dingell Bill.

a. Status of bill unchanged.

b. Indiana State Conference on Social Work to discuss bill.

Curtailment of pre-medical education. Word received from Connecticut that Clare Boothe Luce is to introduce a bill asking for continued deferment of medical students.

(Continued on page xxxv)

(Continued from page 554)

Special bulletin from the American Medical Association in regard to deferment of pre-medical students brought to the attention of the committee.

G. I. Bill of Rights. Copy received from American Medical Association given to Dr. Oliphant for study.

Local

Republican and Democratic state platforms, both containing satisfactory anti-socialized medicine planks, brought to the attention of the committee.

Statewide legislative meeting. An all-day legislative meeting is to be called for Sunday, September 10, at Indianapolis. If a permanent legislative representative at Washington is appointed by that time, he is to be invited to attend this meeting. Arrangements and program for this meeting are to be made by Dr. Beatty and Dr. Wright.

American Medical Association Meeting

Report made in regard to growing importance of Public Relations Committee and unceasing effort of states to have a bona fide Washington office.

Organization Matters

The secretary outlined the work of the Indiana War History Commission and the manner in which medicine and the allied fields are to be covered.

Dr. Oliphant announced the appointment of Dr. Mahlon F. Miller, of Fort Wayne, on the Advisory Committee to the Bureau of Maternal and Child-Health of the Indiana State Board of Health.

Medical Economics

Subscriptions to labor papers. The committee suggested that a list be obtained of labor papers that are approved and endorsed by the A. F. of L. and the C. I. O., and that the association subscribe to only those papers.

Membership in the Indiana State Chamber of Commerce. The committee authorized Dr. Norman Beatty, co-chairman of the Legislative Committee, to investigate a membership in the Indiana State Chamber of Commerce.

Proposed Indiana State Council on Social Agencies. The executive secretary reported upon the contemplated organization of the Indiana State Council on Social Agencies. This proposal is the outcome of a recent conference on juvenile delinquency that was held at Purdue University.

Mass x-ray survey by Indiana Tuberculosis Association. Report made to committee that the Indiana Tuberculosis Association and x-ray group have agreed upon a program for mass x-ray surveys to be made in those counties of the state where these surveys are requested.

Request made that the committee approve the group policy of the Commercial Casualty Insurance Company of the Loyalty Group covering accident and sickness plans for members of professional associations or societies. The committee did not feel that official approval should be given to

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MEDICINE—Two Weeks course in Internal Medicine starting October 16.

GYNECOLOGY—Two Weeks Intensive Course starts October 2. One Week Course Vaginal Approach to Pelvic Surgery starts October 23.

OBSTETRICS—Two Weeks Intensive Course starts October 16.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

GASTROSCOPY—Personal Course starts October 2.

OTOLARYNGOLOGY—Two Weeks Intensive Course starts October 2.

ROENTGENOLOGY—Courses X-ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.

UROLOGY—Two Weeks Course and One Month Course available every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

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any policy of this sort. The fact that the company carries an advertisement in *THE JOURNAL* of the Indiana State Medical Association means that an investigation has been made of the company, and that as far as can be determined the company is reliable and reputable. The committee feels that each county medical society should determine whether or not it desires to carry a group policy with this company.

War and Postwar Medicine

Letter received from the secretary of the Clay County Medical Society, Brazil, Indiana, in regard to the pension claims of veterans, suggesting that instead of placing individual physicians in the position of having to reject these claims, this should be done through some group such as the Red Cross or the Veterans Bureau. He wrote in part: "If we can stop some of these (unfortunate claims), we are going to take a big load off the private physicians and prevent considerable feeling." This communication was given to Dr. Oliphant to answer.

It was the feeling of the committee that there is no necessity for individual physicians to be embarrassed by these requests as apparently the government intends that these men shall make their claims through the Veterans Bureau, and that the service officer of each Legion post will then refer the claim to the service officer of the Indiana Department of the American Legion, who will take it up with the Veterans Bureau. The local service officer will be able to give the soldier full instructions about what evidence he will need, and it will be unnecessary for him to give his family physician anything more than a brief statement of his present condition.

A copy of this letter was sent to Dr. Olin West, secretary of the American Medical Association, as this question of applications for pensions is national in scope.

Reclassification of physicians under thirty-eight years of age. In Indiana there are 334 physicians under thirty-eight in civilian practice. Of these, 144 have been rejected because of physical reasons, 96 have been declared essential, and 14 have been classed in 1-A. The remainder are in miscellaneous categories.

Jackson County situation. Letters received from the secretary of the Jackson County Medical Society, stating that an investigation had been made and that no charges were placed against the two physicians in Jackson County against whom claims have been made that they were charging exorbitant fees.

State Board of Health

Members of the State Board of Health met with the Executive Committee, and Dr. Thurman B. Rice discussed the five-point postwar program. The committee discussed the program and suggested that a special reference committee might be appointed

by the House of Delegates at the annual session to consider this matter.

Socialized Medicine

The committee discussed the statement of Colonel Leonard G. Rowntree, Major General Lewis B. Hershey, and Vice Admiral Ross T. McIntire in regard to the five million wartime 4-F cases. These statistics are to be broken down as it is felt that the medical profession is not at fault for the great majority of these five million men being rejected for service.

Group Hospitalization and Voluntary Health Insurance

Report made by Albert Stump on progress of Blue Cross Plan.

Work of Dr. Howard's Permanent Study Committee on Health Insurance is progressing.

Study of Lay Activities in Medical Practice

Members of Dr. Gatch's committee discussed this problem previous to the Executive Committee meeting, and Dr. Gatch made an informal statement concerning the reason for such a committee. He stated that the committee was not yet ready to make a formal report. An article upon this subject, by Dr. Gatch, is to appear in the August issue of *THE JOURNAL*.

The Journal

Report on financial status of *THE JOURNAL* made by Dr. Weyerbacher.

The committee approved taking "Clinitest" advertisement for *THE JOURNAL*.

The committee approved taking Blue Cross Mutual Insurance Company advertisement.

Committee approved taking Haag's and Hooks' drug store advertisements if copy is suitable.

Question of taking institutional beer advertising to be placed before the Council.

Operative principles for management of the Co-operative Medical Advertising Bureau brought to the attention of the committee, and the committee approved the work upon this committee by Drs. Walter Vest, of West Virginia, Stanley Weld, of Connecticut, and E. M. Shanklin.

Policy upon reprinting articles which appear in *THE JOURNAL* for advertising purposes by commercial houses discussed by the committee. The committee felt that, first, the permission of the author should be obtained for such reprints, and secondly, details concerning such policies should be set by the Editorial Board.

Cancellation of advertisement by Physicians Casualty Association because of non-profit hospitalization and medical service plans brought to the attention of the committee.

Medical Defense

Announcement of official approval of the St. Paul Mercury Indemnity Company to write group mal-

practice insurance to be made in September JOURNAL. An article upon this company is to appear in THE JOURNAL, along with an advertisement. A letter is to be sent to each individual physician in the state.

Malpractice possibilities in EMIC program brought to the attention of Albert Stump. Mr. Stump is to report upon this at the next meeting of the committee.

There being no further business, the meeting was adjourned.

MORE TRUTH THAN—

Dr. John F. Erdmann, busy surgeon who observed his eightieth birthday, when asked by a reporter for the *New York Times* how a busy surgeon could manage to keep up with new developments in medicine, had this to say: "A busy surgeon has to keep up or he won't be a busy surgeon."

—The Lake County Medical News.

"I want some consecrated lye," said the customer to the druggist.

"You mean concentrated lye?"

"It does nutmeg any difference," the man retorted.

"That's what I camphor. How much does it sulphur?"

"Fifteen scents. You're a bright fellow. I never cinnamon with so much wit."

"Thanks—and as yet ammonia beginner at it."

—The Medical World.

FINIS

And the little bug said as he hit the windshield, "That's me all over!"

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—July, 1944

DISEASES	July 1944	June 1944	May 1944	July 1943	July 1942
Tuberculosis, Pulmonary	241	519	137	218	134
Tuberculosis, Other Forms	6	2	3	42	10
Chickenpox	20	182	371	21	29
Measles	52	275	576	344	89
Scarlet Fever	79	192	561	59	39
Typhoid Fever	18	3	9	24	5
Whooping Cough	105	74	46	310	200
Diphtheria	20	13	17	8	13
Influenza	18	4	6	19	15
Pneumonia	12	4	5	12	15
Mumps	31	199	208	44	14
Poliomylitis	49	1	1	3	11
Epidemic Meningitis	15	18	23	7	1
Trachoma	2	1	1	0	0
Septic Sore Throat	2	0	1	0	2
Tularemia	1	0	0	0	0
Undulant Fever	17	10	3	7	2
Impetigo	1	0	2	0	0
Rubella	2	12	10	24	4
Rocky Mt. Spotted Fever	6	0	0	2	2
Rabies in Man	1	0	0	1	0
Tetanus	1	0	1	0	0
Food Poisoning	3	0	0	1	0
Malaria	4	3	0	12	1
Vincent's Angina	2	1	1	0	4

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THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

OCTOBER, 1944

NUMBER 10

PRESIDENT'S ADDRESS *

INDIANA STATE MEDICAL ASSOCIATION

JACOB T. OLIPHANT, M.D.

FARMERSBURG

The beginning of the present year was one of the dark periods in the history of American Medicine. In addition to the general apprehensions of war-time, the doctors were faced with a threat that their profession might be destroyed. A bill had been introduced into Congress which, if enacted into law, would reduce the practice of medicine to the status of a poorly-paid political job. There was strong popular sentiment behind the bill, and a reasonable probability that it would pass. The memory of the years when millions of workers were dependent on the wages of WPA, and when medical services were to be had only through charity, was still fresh in the minds of the people. The Wagner-Murray-Dingell Bill looked to many like an honest effort to provide protection against another such catastrophe.

Congress did not pass the bill. It still lies buried in committee with no prospect of early consideration. Failure of the bill to pass was not due to any concern about what it would do to the doctors. Congressmen, generally, were very little disturbed about upsetting the present doctor-patient relationship, or even about the complete destruction of the liberty of the medical profession. What congressmen did fear was a disastrous effect upon the nation's business by an increase of the Social Security tax rate from one per cent to six per cent, when all other taxes were zooming so rapidly because of the war.

The delay caused by this fear has given the people time to evaluate the results that might follow the introduction of socialized medicine. Those who oppose the measure have had time to marshal their forces and present their arguments. The present prosperous condition of the laboring man has enabled him to enjoy again a high standard of

living and to provide for his own medical wants. There is now no immediate need for the government to concern itself with free medical care.

Let us bear in mind, however, that all of the factors that brought about the threat of socialized medicine are still present in this country. Another financial depression would activate these factors. It behooves us, therefore, to prepare for the return of evil days. In the crisis through which we have passed, the present method of distributing medical services was found to be inadequate. Some better method must be devised before another depression is upon us. The plan proposed by Wagner, Murray and Dingell would cover the situation completely from a political standpoint, but their plan would destroy our freedom and regiment the entire population of the United States. What plan have we proposed? Surely, we are as deeply interested as any other group of citizens in the country, but so far our contribution toward constructive planning has been negligible. Our treatment of the case has been entirely symptomatic. We are waiting for a favorable turn of the disease and hoping that the natural processes of evolution will finally bring about the cure.

It is fortunate that the medical profession has a great and powerful organization, made up of county and state societies from coast to coast. The American Medical Association has within its ranks every doctor of any importance in the entire United States. Therefore, it is reasonable to expect this body to undertake the solution of our problems. So far, the American Medical Association has been very reluctant to assume this responsibility. This reluctance may be due to the wide diversity of opinion which always arises in the consideration of questions of vast importance, and in making plans which have such far-reaching potentialities. We can not object to its taking time for due deliberation, or to a tendency to move with

* Presented before the General Meeting of the Indiana State Medical Association, at Indianapolis, October 4, 1944.

extreme caution, but the gravity of the present medical situation demands that our national association assume its full responsibility of leadership, and that the formation of secondary organizations for the purpose of dealing with our economic problems should be discouraged.

The National Physicians' Committee has done some worthwhile work in creating publicity and in testing public sentiment, but it is not representative of all of the profession. This committee is supported by the voluntary contribution of funds from individual doctors. Last June, Dr. Herman L. Kretschmer, President of the American Medical Association, stated that only 6,227 physicians had supported the committee with donations during the past year. This is only about three per cent of the number of doctors licensed to practice in the United States.

The United Public Health League is an organization formed by the medical associations of six far-western states. It has opened an office in Washington for the purpose of representing its members. This league has expressed its intention of serving only until the American Medical Association is ready to take over its functions.

The Association of American Physicians and Surgeons was formed in Lake County, Indiana. Its purposes are similar to those of the other two, but it differs somewhat in its approach.

Your state association has not recognized officially any of these new organizations, but has sought to cooperate with the societies of neighboring states that share in the belief that all of the medical profession should be represented by the American Medical Association. We believe that if we divide our forces we shall diminish our strength.

DOMESTIC AFFAIRS

The work of your association was greatly facilitated this year by certain mandates of the House of Delegates at last year's session. Your officers and committees feel some satisfaction that all of these mandates have been carried out.

We are gratified with the success of the publicity campaign which was initiated through the Secretaries' Conference. In this, dozens of our members from all sections of the state have had an active and effective part. The plan served as a model for many other states, and thus became another

"Indiana plan." The Committee on Industrial Health, with the Indiana University School of Medicine and the Indiana State Board of Health, put on the most ambitious meeting for the training of industrial health physicians that has been undertaken by any state. The Committee on the Permanent Study of Health Insurance has brought in a notable report. The Committee on the Study of Lay Activity in Medical Practice has made a definite contribution, and its report deserves careful consideration. In fact, the work of all of the committees has been outstanding. Their reports, now before the House of Delegates, constitute a comprehensive review of all of the problems confronting us, with definite and concrete recommendations for their solution.

There has been an excellent spirit of harmony among our members, and every man called upon to serve has given willingly of his time and effort to the task that has been assigned to him. This hearty cooperation and unfailing readiness has been deeply appreciated by your officers. We wish to express our gratitude to everyone who has aided us in any capacity.

POST-WAR PLANS

Much ground has been covered by the studies of the various committees this year. When all of their reports have been considered by the delegates and final action has been taken on their many suggestions, the result should constitute a very complete plan for the direction of this association for the coming years.

OUR DOCTORS IN WAR

For the past many months our minds have been constantly occupied with thoughts of our members who are now on the battle-fronts. We have missed them sorely. Now that complete victory seems so much nearer, we are beginning to look forward to the day when they will return. Their brilliant achievements have won for them the admiration and good-will of all of the people at home. There is nothing we can do to restore them to a place in the hearts of the fathers and mothers of our fighting men; their skill and their devotion to duty have made that place secure, but we can help to restore to them their old place in the practice of medicine. We can send back to them the patients who have come to us in their absence. We can see to it that no one takes advantage of their sacrifice. These things we solemnly pledge ourselves to do.

ABSTRACT: PENICILLIN SUCCESSFULLY USED FOR INFECTION OF EYE SOCKET

The successful treatment with penicillin of a case of orbital cellulitis is reported by H. O. Sloane, M.D., Philadelphia, in *The Journal of the American Medical Association* for September 16.

The case reported was that of a boy of twelve whose left eye was involved, the infection originating in one of the sinuses. Sulfadiazine was tried without affecting the

condition in any way and operation was contemplated both for the sinus condition and locally to establish drainage and relieve the inflammation and swelling of the tissues in the socket of the left eye. However, Dr. Sloane says, under the continued use of penicillin administered by injection into a vein for a period of ten days the condition cleared up completely, so that it was unnecessary to operate.

ROENTGEN THERAPY OF FUNCTIONAL AMENORRHEA AND STERILITY

JOHN A. CAMPBELL, M.D.*

INDIANAPOLIS

Evidence is rapidly accumulating to show that the application of low-dosage roentgen therapy to the pituitary body and ovaries can restore normal cyclic menstruation and correct sterility in many cases of functional amenorrhea or abnormal uterine bleeding due to endocrine dysfunction. Certain endocrine disorders of the pituitary, ovary, thyroid, and suprarenal glands are known to cause functional disturbances in menstruation. Frequently cases of functional amenorrhea or oligomenorrhea will show characteristic findings of endocrine dyscrasia in the form of pituitary pressure symptoms, hirsutism, defeminization, obesity, and sugar intolerance. More often, however, these findings are either totally absent or present only to a suggestive degree. In either instance, symptoms of the climacteric are seldom present, and the other physiological causes for such a state are lacking. These are not cases of profound ovarian failure with non-functioning ovaries and an atrophic uterus, but rather those in which there exists a fair degree of ovarian function and a normal-sized uterus. A normal premenstrual level of estrogenic substance is generally found in the urine. The endometrial biopsies usually show a follicular or a premenstrual secretory endometrium of a type which reflects a disturbance but not a failure of ovarian function.

Such cases of secondary amenorrhea and oligomenorrhea are often benefited by the use of substitution endocrine therapy directed at correcting hypofunction of the pituitary, thyroid, and ovaries. This form of treatment, however, on many occasions fails to be of lasting benefit, requires large amounts of medication, and is costly and time-consuming to both the patient and the physician. Radiation therapy, on the other hand, when properly given, has produced excellent results in a high percentage of cases, many of whom had failed to respond to previous organotherapy.

Although we do not know the real cause of menstrual bleeding, recent endocrine studies have shown a definite interrelationship of the pituitary, thyroid, and ovaries. It is now generally acknowledged that the menstrual cycle is dependent upon the harmonious interaction of the gonadotropic hormones of the basophilic cells of the anterior pituitary lobe and the estrogenic and luteal hormones of the ovary. The follicular stimulating prolan A of the anterior pituitary must be present to insure the maturation of the ovarian follicle and the proper secretion of estrin. Likewise, it seems that the luteinizing hormone prolan B of the anterior pituitary must be present in a proper amount

to maintain the normal physiological development of the corpus luteum of the ovary and its important hormonal product, progesterin. A disturbance or variation in any portion of this chain of endocrine factors, if sufficiently pronounced, will inevitably affect this intimate relationship and result in menstrual dysfunction and sometimes sterility. Functional amenorrhea, therefore, probably results from a defect in the synchronism of the whole triangular mechanism of the pituitary, ovary, and uterus, with the thyroid activity depending chiefly on the balanced action of the pituitary.

Sterility is usually due to a combination of faults in both the male and female, but it may be due only to a failure of the endocrine glands concerned with reproductive functions in the female. This type of sterility may or may not be associated with disturbance of the menstrual cycle. The sterility is due to the fact that either an egg is not being extruded from the ovary each month, the so-called "anovulatory type of menstruation,"¹ or it may be due to a defective or absent progesterational or premenstrual phase so that the lining of the uterus is improperly prepared to receive the fertilized ovum. Therapy directed toward stimulation of the ovary often overcomes these faults and makes pregnancy possible.

As early as 1905, Halberstaeder demonstrated the definite sensitivity of the ovaries to roentgen rays. At first the effect of the rays was thought to be specific only in suppressing ovarian function, and not until 1915 when Van de Velde noted bleeding following small doses of x-ray to the ovaries where they suggested as a possible means of stimulating dormant or sluggish gynecological functions. In 1924, Rougy reported the resumption of menstrual function following small doses of x-ray applied to the ovaries. In 1926, Rubin² and Hirsch³ reported successful treatment of twelve cases of amenorrhea and sterility by this method. Since then Kaplan, Dripps, Ford and others have reported numerous successful results, using low doses of ovarian irradiation alone. B  cl  re first reported the effect of x-ray therapy on the pituitary, and Werner found that such treatment stimulated menstrual reaction. This prompted its use for mitigating

¹ Bruck, S., and Fruchter, J. M.: Roentgen Treatment of Menstrual Dysfunctions and Sterility; Analysis of 108 Cases, *Radiology*, **32**:446-453 (April) 1939.

² Rubin, I. C.: Sterility Associated with Habitual Amenorrhea Relieved by X-ray Therapy, *Am. J. Obstet. and Gynec.*, **12**:76-88 (July) 1926.

³ Hirsch, I. S.: X-ray Treatment of Hypofunction of Ovary, with Special Reference to Regulation of Menstrual Function, *Radiology*, **7**:93-103 (Aug.) 1926.

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early climacteric symptoms. Kotz and Parker⁴ recently restored normal menstrual function in 56 per cent of their patients with irradiation of the pituitary alone.

Kaplan, in 1931, first mentioned the use of combined ovarian and pituitary radiation in amenorrhea. Recently the technic of combined treatment has been perfected by Kaplan, Mazer, and Edeikin, and the results have been considerably improved.

Edeikin⁵ recommends that x-ray therapy, using 135 kv., 5 ma., 35 cm. target-skin distance, and filtered through $\frac{1}{4}$ mm. Cu. and 1 mm. Al., be administered so that the pituitary receives 50 to 90 r. air units through a 5 x 5 cm. temporal portal at weekly intervals for three weeks, and each ovarian pelvic area receives 50 to 90 r. air units weekly for three treatments through alternating anterior and posterior 10 x 12 cm. portals.

Kaplan⁶ advises factors of 200 kv., 4 ma., 0.5 mm. Cu. plus 1 mm. Al. filter, with a target distance of 30 to 40 cm. Treatment is directed through the anterior and posterior right and left pelvic fields, using 9 x 12 cm. to 12 x 15 cm. portals, and to the pituitary area through a 3 x 3 cm. temporal field. A dose varying from 75 to 150 r. measured in air is given weekly for three weeks. The pelvis is irradiated anteriorly the first week, posteriorly the second week, and anteriorly the third week. The pituitary is given similar dosage at the time the pelvis is treated anteriorly.

Both of these methods deliver approximately the same total roentgen dosage. In general, the total dosage reaching the ovaries and pituitary is about 35 to 50 tissue roentgens. In cases which show clinical signs pointing to definite pituitary insufficiency, the total dosage to this structure may be safely increased to several times that mentioned above since the anterior lobe is most resistant to destruction by irradiation, and a greater stimulating effect may be obtained.

Most of the writers on this subject believe definitely that the small doses of therapeutic irradiation applied to the ovaries for amenorrhea and sterility, when properly administered, will not produce harmful effects upon either the mother or her offspring. But this is a controversial issue, chiefly because not enough time has elapsed for observation of the second generation borne to mothers who have been irradiated. Experimentally,⁷ it has been shown that the litter of irradiated mice or the succeeding generations of irradiated seedlings differ both in quantity and quality from those of controls even when the x-ray dosages used were

very small. Whether these eugenic malformations and transmission of phases of irregular tendencies to progeny by parents to whom irradiation has been given hold true in the human species as they do on rodents is not known. It is reasonable to assume that low dosage irradiation of the ovaries has no deleterious effect on the human offspring of the first generation since none has ever been recorded, but it is not entirely logical to conclude that the hereditary characteristics of the offspring have not been altered. Obviously, observation of many succeeding generations of irradiated patients is necessary to prove this point. The fact remains, however, that the erroneous concept that x-rays invariably cause structural, and consequently functional deterioration of human cells is at least partly responsible for the reluctance of the profession to employ one of the most valuable agents in the treatment of amenorrhea. In cases where pituitary radiation alone brings adequate results, the problem of influencing heredity can, of course, be completely avoided.

Whether roentgen irradiation directly affects the ovaries, the uterus, or the pituitary, or is an indefinite stimulant of the interacting endocrinologic factors, is debatable. Wagner and Schoenoff⁸ irradiated one ovary with 5-10 per cent S.E.D. and carefully protected the other ovary in thirty-eight patients who were to have elective pan-hysterectomies. Several weeks later the ovaries were removed, and the histological appearance of the irradiated ovaries was no different than that of the control ovaries. No degenerative effects were found. This supports the contention that such small doses of x-ray could not possibly produce structural destructive changes. Although Stein and Leventhal⁹ have shown that cases of polycystic ovaries can be relieved of associated amenorrhea and sterility by mechanical destruction of the cysts, it seems doubtful if similar proved cases relieved by roentgen therapy could be explained on the same basis.

Kaplan suggests that perhaps the roentgen rays act by destroying the inhibitory function of a persistent corpus luteum which may have suppressed menstruation and caused subsequent sterility. Of fifty-eight of his cases who became pregnant following roentgen therapy, thirty-three had had previous pregnancies before the onset of varying periods of amenorrhea. Sixteen of these thirty-three pregnancies resulted in normal children, and seventeen in miscarriage. Some of these cases were treated by ovarian radiation alone, which obviates the pituitary effect.

Wolf, in collaboration with Kaplan, has studied endometrial biopsies of patients with amenorrhea

⁴ Kotz, J., and Parker, E.: Treatment of Functional disorders of Female by Radiation of Pituitary Gland, *South. Med. J.*, **33**:832-839 (Aug.) 1940.

⁵ Edeikin, L.: Small Doses of X-ray for Amenorrhea and Sterility, *Am. J. Obstet. and Gynec.*, **25**:511-516 (April) 1933.

⁶ Kaplan, I. I.: Irradiation with Small Doses in Treatment of Functional Gynecological Conditions, *Am. J. Roentgen and Radium Therap.*, **42**:731-744 (Nov.) 1939.

⁷ Friedman, A. B., and Seligman, B.: X-ray Therapy in Amenorrhea, *Radiology*, **29**:99-103 (July) 1937.

⁸ Wagner, G. A., and Schoenhof, C.: Experimental and Histologic Research on Mode of Action of Smallest Doses of Roentgen Rays on Human Female Sex Glands, *Strahlentherapie*, **22**:125-140, 1926.

⁹ Stein, I. F., and Leventhal, M. L.: Amenorrhea Associated with Bilateral Polycystic Ovaries, *Am. J. Obstet. and Gynec.*, **29**:181-191 (Feb.) 1935.

and postulates three possible causes for the symptoms: (1) Absence of function of the anterior pituitary lobe, especially of the basophilic cells. (2) Excessive amounts of follicle-stimulating hormone, producing single or multiple granulosa cysts in the ovary without corpus luteum formation and with resultant hyperplastic endometrium. (3) Excess of luteinizing gonadotropic hormone which gives rise to persistent cystic corpus luteum of the ovary and a premenstrual endometrium.

From these findings, Wolf concludes that in Group 1 roentgen therapy to the ovaries alone is of no avail, but that radiation of the pituitary might stimulate its function. In Group 2 he suspects that x-rays inhibit or destroy the persistent follicle, permitting ovulatory bleeding. In Group 3 he credits the roentgen therapy with destroying the persistent corpus luteum, resulting in bleeding from a premenstrual endometrium.

Kotz and Parker⁴ record that 78 per cent of their cases had sufficient disturbance of ovarian function to cause abnormal endometrial studies. Of 115 cases, twenty-five showed normal secretory endometrium; forty-two showed abnormally-developed secretory reaction; and forty-eight showed follicular endometrium, twenty-three of whom represented anovulatory menstruation. Repeated endometrial biopsies in thirty-two of the cases treated by pituitary irradiation alone indicated that ten cases previously abnormal were restored to normal function, while five were improved.

Rock¹⁰ and his associates believe that the menstrual periodicity is upset by the presence in the ovary of one or more follicles which have matured, but which have failed to rupture and pass through a normal corpus luteum stage. They believe that x-ray acts by destroying these cysts, or by completing their maturation.

In the light of these seemingly conflicting clinical and experimental observations on the action of low-dosage irradiation to the pituitary and ovarian glands, the independence of the functional from indiscernible structural changes in the cells must be conceived. Until more of the mysteries of endocrine physiology are understood, it will probably be best to countenance a dose of roentgen rays too small to produce even microscopic changes in the cell, yet capable of modifying its functional activity, possibly through indiscernible effects.

At the present time some are inclined to attach prime importance to the treatment of the pituitary body in restoring normal menstrual function. But, although pituitary irradiation alone appears to be efficacious, it cannot be denied that ovarian radiation alone has produced many successful results. In keeping with the evident fact that normal genital function of the female depends on the proper correlation of the endocrine activity of the pituitaries and ovaries, it seems logical that the best results

follow selective roentgen therapy to both structures in minimal dosages.

All of the workers in this field are highly enthusiastic about their results. Mazer, Reidenberg, Taylor, and others, state that organotherapy is far less effective than irradiation of the affected endocrine glands in the successful re-establishment of menstrual periodicity. Since 1924, Kaplan has followed 156 cases treated for amenorrhea of one month to fourteen years' duration, and sterility from one to eighteen years, and of these the menses were regulated in 103 patients. There was no improvement in fifty-six cases. The results were most successful in the 21 to 29 age-group, and most of the failures occurred in the 30 to 45 age-group. Fifty-one of the 103 became pregnant, and forty-four went to term and gave birth to fifty normal living children. Seven conceived but aborted, and two of these were self-induced.

Mazer,¹¹ in 1943, reported on ninety-two cases. Ten of these had no menses from sixteen months to six years, and five (50 per cent) are now regular in from one to five years' of observation. Twelve of the ninety-two cases menstruated on six-month cycles. Eight of these (66 per cent) are having normal menses. Sixty-eight of the ninety-two had oligomenorrhea with two to four month cycles. Fifty-two, or 76.5 per cent, of these have been menstruating normally from one to five years. A second course of therapy was given to ten of the ninety-two cases. Three of these were restored to normal function following the second dose. Mazer points out that the percentage of cures is inversely proportional to the severity of the amenorrhea. Thus, those who had menstruated at intervals of two to four months yielded the highest number of successes. Thirty of fifty-four infertile women conceived at variable intervals after the completion of treatment. Twenty-eight delivered normal infants, and the remaining two aborted during the first trimester. Twenty-one of thirty conceived within four months after combined low-dosage treatment, and a few without any intervening menstrual flow. Complete restoration of the menstrual function for over one year in nineteen of the twenty-one women who conceived soon after treatment implies that conception was the result of stimulated ovarian activity. Two successful pregnancies followed a second course of irradiation given after the first course failed to completely restore menstrual function. Of Mazer's ninety-two cases, 62 per cent are menstruating normally.

Reidenberg¹² reports a long-term survey of 136 patients followed for three to thirteen years. Restoration of normal menstrual function occurred in 71 per cent of fifty-one women with amenorrhea,

¹¹ Mazer, C., and Greenberg, R.: Low-dosage Irradiation in Treatment of Amenorrhea: Analysis of Additional Ninety-two Cases, *Am. J. Obstet. and Gynec.*, **46**:648-654 (Nov.) 1943.

¹² Reidenberg, L.: Low-dosage Irradiation to Pituitary Gland and Ovaries in Amenorrhea and Dysfunctional Uterine Bleeding: Long-term Survey, *Am. J. Obstet. and Gynec.*, **45**:971-979 (June) 1943.

¹⁰ Rock, J.; Bartlett, M. K.; Gauld, A. G.; and Rutherford, R. N.: Effect of Subastrative Roentgen Therapy on Ovarian Physiology, *Surg., Gynec., and Obstet.*, **70**:903-913 (May) 1940.

78 per cent of thirty-seven with oligomenorrhea, 57 per cent of seven with hypomenorrhea, 59 per cent of twenty-seven with menorrhagia, and 50 per cent of ten with metrorrhagia. Four patients with primary amenorrhea were unaffected. The percentage of cures for the whole group was sixty-six. Forty-four were either unaffected or only temporarily improved. The return of menstrual function in fifty-seven patients with associated sterility materially aided conception in thirty-four cases. Of ninety pregnancies in fifty-four women, eighty resulted in full-term healthy offspring.

Through the interest and co-operation of Dr. Carl P. Huber, of the Department of Gynecology and Obstetrics, we have had an opportunity to give combined low-dosage pituitary and ovarian irradiation to a small series of patients in an effort to evaluate this form of therapy. A total of twelve patients have been followed from six to eighteen months, all of whom had clinical pelvic abnormalities ruled out by careful gynecological examinations. Ages ranged from 19 to 37. Nine patients were married, and only one of these had been previously pregnant. Eleven patients had clinical trials of endocrine therapy, and were selected for radiation treatment only after the response to organotherapy was deemed not wholly satisfactory. All of the patients had true menstrual dysfunction.

One patient with primary amenorrhea showed no improvement following radiation. Five patients with functional amenorrhea are now menstruating normally. Of six patients with oligomenorrhea, three have resumed normal menstruation, one is improved and showing normal menses on a six-week cycle, while two remain unimproved. Three patients with histories of amenorrhea and sterility have become pregnant since treatment was concluded. One of these three patients is now pregnant for the second time since treatment. Following a positive Friedman test she aborted her first pregnancy after seven weeks of gestation, and is now in the second month of a subsequent pregnancy. The second patient aborted during the fourth month of gestation, while the third patient is in the second trimester of a seemingly uneventful pregnancy.

Eight of our twelve patients still have a restoration of normal menstrual function. Three failed to show any benefit, and one is improved to a point where a second course of treatment is being considered. We realize that our sample is too small to permit statistical deductions, but it has afforded us an insight into the possible merits of this procedure since all of our patients were refractory to the usual forms of corrective gynecological treatment.

	Total	Menstruating Normally	Per Cent	Failure	Sterility Relieved
Kaplan	163	103	63	56	44
Mazer	92	65	62	27	30
Reidenberg	136	90	66	46	34
Indiana University..	12	8	66	3	3
Kotz and Parker.....	243	136	56	107	23


(Pit. alone)

CONCLUSIONS


It would seem that the enthusiasm expressed by the prominent exponents of low-dosage irradiation of the pituitary body and ovaries in the treatment of menstrual irregularities and sterility has actually been of such a degree as to cause undue skepticism on the part of many gynecologists and radiologists. Perhaps the controversy over the possible harmful effects of preconceptional low dosage of x-rays to the ovaries has caused us to lose sight of the fact that a permanent restoration of a properly-balanced pituitary-ovarian endocrine function in patients refractory to other forms of treatment is in itself of much benefit. The fact remains that the results of reputable observers in sufficiently large groups of cases are remarkably uniform, and these results can be reproduced by using their methods. No deleterious effect from this type of treatment has ever been recorded on the generative organs of the patient or in the first generation offspring. It is known that a blighted ovum may arise more commonly from a subnormally-functioning ovary than from a normal one. Ovarian stimulation of sterile women by any therapeutic means carries this rather remote hazard, and yet the large number of normal children born to these patients makes it illogical to withhold any form of efficient and safe treatment.

Low-dosage irradiation is not a cure-all for menstrual disorders but should be offered to a well-selected group of patients who have first had proper gynecological study and evaluation. Patients with functional amenorrhea or oligomenorrhea probably due to an endocrine disturbance which does not respond rather promptly to conservative therapy should be considered as candidates for low-dosage treatment. When sterility is an associated important factor, the patient will have a much better chance of conception if treatment is carried out before the age of thirty. Restoration of normal menstruation usually takes place within six or eight weeks following x-ray.

Low-dosage therapy to the ovaries and pituitary should be given strictly according to the technic established by Edeiken or Kaplan. Increasing the dosage does not increase the beneficial results. A properly selected patient should have a 65 per cent chance of regaining normal menses, often accompanied by general improvement in other endocrine functions, and a 50 per cent chance of relief from sterility. This form of therapy can, therefore, play a very helpful role to the gynecologist in the management of endocrine dysfunctions causing ovarian and menstrual irregularities.



Riddle the Robot
Bombs with
Bonds



THE EFFECT OF EXERCISE ON THE ELECTROCARDIOGRAM IN ADOLESCENT BOYS

DAN L. URSCHER, M.D.*

MENTONE

The effect of exercise on the electrocardiogram has been frequently studied, both in normal and in pathologic subjects. There exists a general agreement on the significance of certain major changes in the curve following exercise, but various opinions remain regarding the less prominent changes. There are also differences of opinion regarding the amount of exercise which should be used to induce these changes. Master¹ has done extensive work on a "two-step test" of exercise tolerance, which he feels can be used to provide a standard amount of exercise, depending on sex, weight, and age of the patient, without danger to the patient's cardiac condition. He has published several articles on the electrocardiographic changes occurring in normal individuals and in patients with various types of cardiac pathology.^{2,3} His method seems much safer than that of Twiss and Sokolow,⁴ who exercised their patients on stairs until pain appeared or dyspnea developed. However, it may well be argued that electrocardiographic changes do not occur in patients with angina pectoris until pain develops. The effects of exercise on the normal heart have been extensively studied, particularly in athletes. Tuttle and Korns,⁵ Butterworth and Poindexter,⁶ and Barrow and Ouer⁷ report their own work in this, and review the significant literature on the subject.

During the past several years there has been considerable agitation in the state of Indiana for a change in basketball tournament procedure. This led, six years ago, to the adoption of a program whereby no team plays more than two games per day in any tournament. With the previous method, winning and runner-up teams would usually be called upon to play three games during the day. Inasmuch as these games were being played by

high school boys, many of whom had not reached full physical development, it was felt that some permanent cardiac damage might be sustained through such vigorous play. Requirement of a doctor's certificate of examination has been standard for some time. Many schools have the boys examined in a group at the school, while others allow them to go to whatever physician they choose. There are many advantages for the first of these methods. In these busy times it is a source of some annoyance for a physician to have to examine boys in his office during his regular hours. A boy with some heart lesion may be able to get his certificate signed merely because the physician is too rushed to do a thorough examination. In some cases the lesion will be prominent only after exercise of vigorous nature, and these will not be detected in the office. The most important advantage, however, is in having the same physician do the examining year after year, so that progress of lesions can be checked.

Through the intelligent and thorough cooperation of the basketball coach in a nearby school, the writer has been enabled to conduct studies on the effect of exercise on the same group of boys for several years. These boys have been studied by electrocardiography and teleoroentgenography, and unless interscholastic athletics are curtailed by the war, progress studies on the same boys will be continued through four years of competitive athletics.

The work reported in this paper covers only the immediate effects of exercise on the electrocardiogram on these boys at the beginning of their freshman year. The exercise was a basketball game in which all participated. The electrocardiograms were made just before and immediately following the game. The boys were taken from the game one at a time, so that none of them rested before the after-exercise curve was taken. One of the boys was thirteen years of age, three were fourteen, and one was fifteen. All electrocardiograms were taken with the subjects lying down. The precordial lead was CF4.

RESULTS

Results are illustrated in the accompanying before-and-after electrocardiograms, and summarized below:

Patient No. 1 (L.A.): In this boy the changes in the P wave were most pronounced. P1 decreased slightly in height; P2 changed from a diphasic to a sharply upright position; P3 changed from an inverted to an upright position, and P4, which was upright before exercise, became inverted following

* Now serving with the armed forces.

¹ Master, A. M.: The Two-Step Test of Exercise Tolerance, *Am. Ht. Journal*, 10:495, 1941.

² Master, A. M.: The Electrocardiogram After Exercise, *U. S. Naval Medical Bulletin*, 40:346-351 (April) 1942.

³ Master, A. M., and Jaffe, H. L.: The Electrocardiographic Changes After Exercise in Angina Pectoris, *J. Mt. Sinai Hosp.*, 7:629 (March-April) 1941.

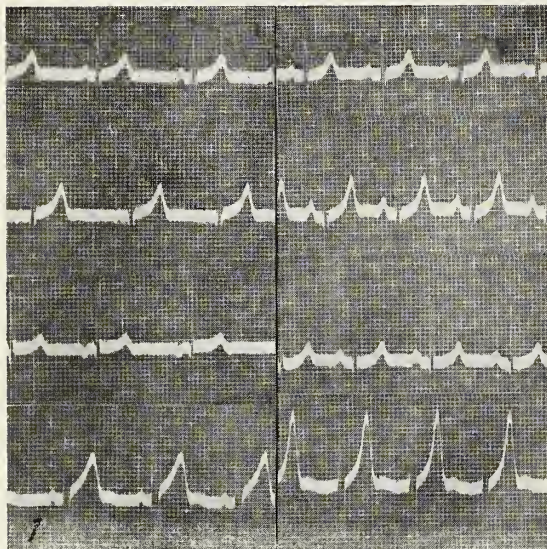
⁴ Twiss, Arthur, and Sokolow, Maurice: Angina Pectoris, Significant Electrocardiographic Changes Following Exercise, *Am. Ht. Journal*, 23:498-512 (April) 1942.

⁵ Tuttle, W. W., and Korns, H. M.: Electrocardiographic Observations on Athletes Before and After a Season of Physical Training, *Am. Ht. Journal*, 21:104-107 (January) 1941.

⁶ Butterworth, J. S., and Poindexter, C. A.: An Electrocardiographic Study of the Effects of Boxing, *Am. Ht. Journal*, 23:59-63 (January) 1942.

⁷ Barrow, W. H., and Ouer, R. A.: Electrocardiographic Changes with Exercise; Their Relation to Age and Other Factors, *Arch. Int. Med.*, 71:547-554 (April) 1943.

Figure 1



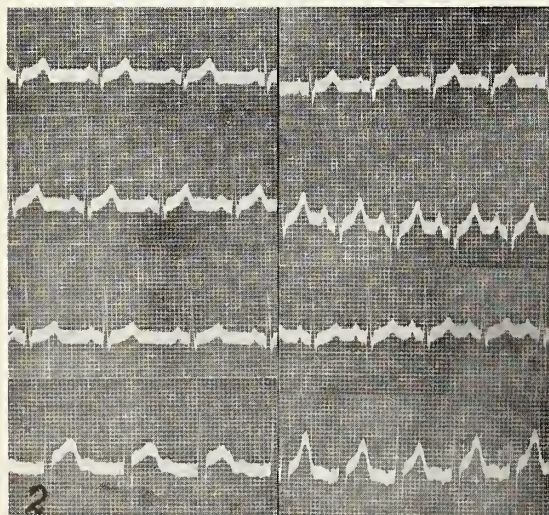
Patient No. 1 (L. A.): Electrocardiograms before (left) and after (right) exercise.

There were no changes in the QRS complex. T2, T3, and T4 became higher following exercise. ST segments showed no changes.

Patient No. 2 (M.S.): In this boy the P waves showed little change except an increase in height in the second lead. The QRS complexes were unchanged except for slight deepening of Q2 and S2. ST segments in the standard leads showed no change, but in the precordial lead a high, coved, ST segment became normal in appearance following exercise.

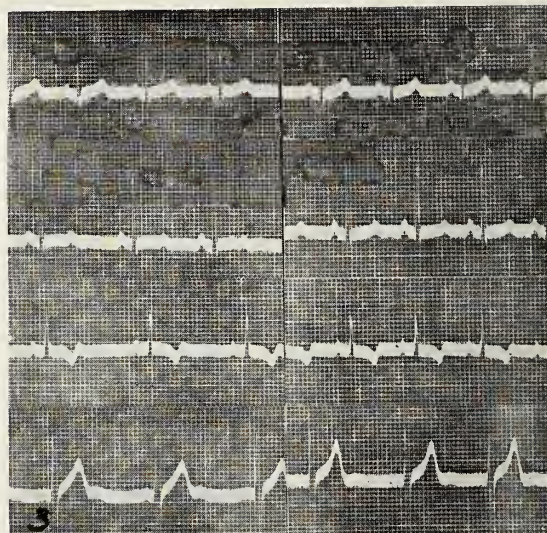
In Patient No. 3 (S.H.) there were no changes in the P wave or in the QRS complexes. The ST segments also showed no change. A diphasic T2

Figure II



Patient No. 2 (M. S.): Electrocardiograms before and after exercise.

Figure III



Patient No. 3 (S. H.): Electrocardiograms before and after exercise.

became normally upright, while an inverted T3 became slightly less negative.

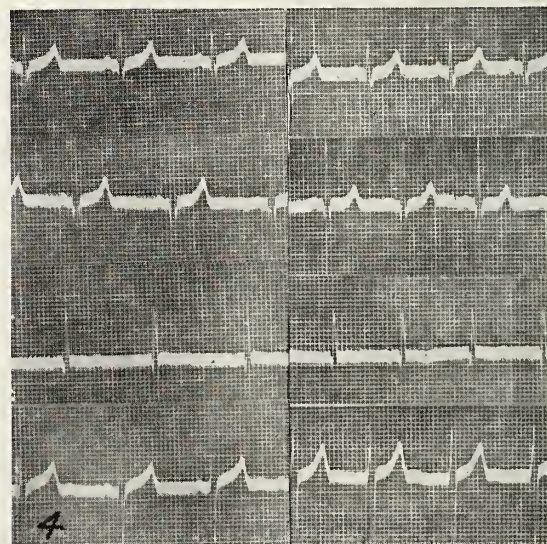
In Patient No. 4 (B.B.) there were almost no changes. Q2 became less prominent, and T3 changed from iso-electric to a very slight inversion.

In Patient No. 5 (H.F.) likewise, there were few changes. The P waves became somewhat sharper in the standard leads. QRS complexes were unchanged. An iso-electric T3 became upright.

COMMENT

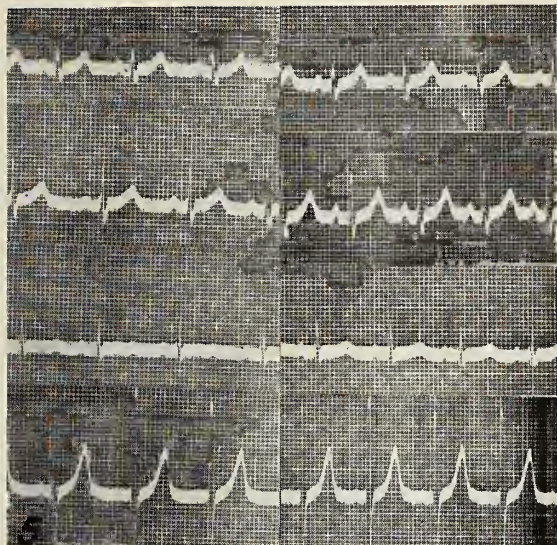
In this group of normal adolescent boys participating in vigorous athletics at the start of the school year, there were very few electrocardiographic changes noted in the curves taken before

Figure IV



Patient No. 4 (B. B.): Electrocardiograms before and after exercise.

Figure V



Patient No. 5 (H. F.): Electrocardiograms before and after exercise.

and after exercise. All had been previously examined and x-rayed, and none showed evidence of any cardiac pathology. The P wave changes in Patient No. 1 were the only marked changes in the entire series. The QRS complexes remained constant, as did the ST segments in all except the

precordial lead in Patient No. 2. Minor variations in the T wave were fairly common, as one might expect. Also, as was to be expected, the T wave changes in Lead III were most unpredictable. T2 became higher in all but one of the boys. T3 became higher in three, less negative in one, and more negative in one. T4 became higher in all five.

CONCLUSIONS

Electrocardiograms were taken before and after vigorous exercise in a group of five high school freshmen, ranging in age from thirteen to fifteen years. These electrocardiograms were made at the beginning of an athletic season while the boys were in relatively poor condition.

There were no notable electrocardiographic changes from exercise in this group. The QRS complexes, in particular, remained almost unchanged. The P waves became somewhat sharper, and in one patient became sharply upright after having been diphasic or inverted. ST segment changes were almost entirely absent. Respiratory sinus rhythm became much less marked after exercise. The height of T4 was increased by exercise in all cases. The height of T2 was increased in four. T3 showed no constant change. T1 showed little change.

From this series it would seem that vigorous exercise does not produce any characteristic changes in the electrocardiograms of normal adolescent boys.

PERTUSSIS AGGLUTINATION BY THE RAPID METHOD

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INTRODUCTION

Serologically, *Hemophilus pertussis* when freshly isolated is a homogeneous organism, and this species is made up of bacteria of only one agglutinative type. Fortunately, therefore, "typing" is not a problem, and in this respect the bacteriology of pertussis is relatively simplified and differs from that of pneumococcus pneumonia with its multiplicity of types.

When *Hemophilus pertussis*, however, is cultivated in the laboratory under poor conditions, including for example the use of agar culture media with too little blood added for enrichment, the organism deteriorates not unlike many other fastidious human pathogens. Proper methods of cultivation, including the use of Bordet agar enriched with 25 to 30 per cent of blood, however, assure the maintenance for some time of *Hemophilus pertussis* in phase I of Leslie and Gardner.¹ Ac-

cording to a more generally used terminology, this stage of the organism should be called the "S" form as defined by Shibley and Hoelscher,² and in this report our reference to *Hemophilus pertussis*, unless otherwise defined, is restricted to cultures in the "S" form.

IMPORTANCE OF PERTUSSIS AGGLUTININ

It is obvious from the above facts that the "S" agglutinin and corresponding agglutininogen assume added importance in pertussis immunity. This is indicated by work recently reported by Miller and associates³ on agglutinin titers of the blood of human beings treated with pertussis vaccine, and agglutininogen skin tests of such individuals as a measure of blood and fixed tissue agglutinin as

* From The Lilly Research Laboratories, Indianapolis, Indiana.

¹ Leslie, P. H., and Gardner, A. D.: The Phases of *Hemophilus Pertussis*, *J. Hyg.*, **31**:423-434, 1931.

² Shibley, G. S., and Hoelscher, H.: Studies on Whooping Cough. I. Type Specific (S) and Dissociation (R) Forms of *Hemophilus Pertussis*, *J. Exp. Med.*, **60**:403, 1934.

³ Miller, J. J., Jr.; Silverberg, R. J.; Saito, T. M., and Humber, J. B.: An Agglutinative Reaction for *Hemophilus Pertussis*. I. Persistence of Agglutinins after Vaccine, *J. Pediat.*, **22**:637-643, 1943.

reported by Flosdorf, et al.⁴ In a report just received from England, Evans⁵ has shown by experimental methods that pertussis antibacterial serum when given intravenously exhibits strong mouse-protective action against living *Hemophilus pertussis* administered intranasally, and furthermore this protective action is associated with agglutinins. Protective effect of so-called "pertussis antitoxin" was evident only when such antitoxin was given intranasally.

THE RAPID PERTUSSIS AGGLUTINATION TEST

In order to simplify and expedite serological testing of both whole blood and serum, a rapid one-minute pertussis agglutination test has been devised and described by Powell and Jamieson.⁶ This test is conducted by adding a small drop of blood or serum to a small drop of the blue antigen (colored blue with methylene blue) on a slide or, preferably, on a piece of glazed waterproof cardboard. The combined drop is stirred a few seconds, then the slide or card holding it is rocked back and forth for about a minute. If the blood or serum contains appreciable antipertussis agglutinating antibody, the progress of ensuing agglutination can be seen as granulation and clumping of the blue colored antigen gradually take place.

This rapid test is adapted for assay of newly-prepared lots of pertussis vaccine in mouse tests, as reported by Powell,⁷ and also for assay of pertussis immunity attained in human beings at various periods following immunization with commercial vaccine according to reports by Lapin,⁸ Daughtry-Denmark,⁹ Sako,¹⁰ and Powell and Jamieson.¹¹ Use of this test brings about a saving in time, equipment, and material, and the results may be read so promptly that it may be used as a bedside test. In the present report the conduct and appearance of this rapid pertussis agglutination test are described in detail.

⁴ Flosdorf, E. W.; Felton, H. M.; Bondi, A., and McGuinness, A. C.: Intradermal Test for Susceptibility to and Immunization against Whooping Cough Using Agglutinin from Phase I *Hemophilus Pertussis*, *Am. J. Med. Sci.*, **206**:421-425, 1943.

⁵ Evans, D. G.: The Protective Properties of Pertussis Antisera in Experimental Infection, *Jour. Path. and Bact.*, **56**:49-54, 1944.

⁶ Powell, H. M., and Jamieson, W. A.: A Rapid Pertussis Agglutination Test, *J. Immunol.*, **43**:13-15, 1942.

⁷ Powell, H. M.: Rapid Pertussis Agglutination Tests of Circulating Antibody in Stock and Swiss Mice Treated with Phase I Pertussis Vaccine, *J. Bact.*, **43**:119, 1942.

⁸ (a) Lapin, J. H.: Combined Immunization of Infants Against Diphtheria, Tetanus and Whooping Cough, *Am. J. Dis. Child.*, **63**:225-237, 1942.

(b) Lapin, J. H.: Mixed Immunization in Infancy and Childhood, *J. Pediat.*, **22**:439-451, 1943.

(c) Lapin, J. H.: Whooping Cough Vaccines, *J. Pediat.*, **22**:452-458, 1943.

⁹ Daughtry-Denmark, L.: Whooping Cough Vaccine, *Am. J. Dis. Child.*, **63**:453-466, 1942.

¹⁰ Sako, W.: Early Immunization Against Pertussis, *New Orleans Med. and Surg. J.*, **95**:565, 1943.

¹¹ Powell, H. M., and Jamieson, W. A.: Rapid Pertussis Agglutination Tests of the Blood of One Hundred Normal Adult Persons, *Proc. Ind. Acad. of Sci.*, **52**:30-33, 1943.

RESULTS OF RAPID AGGLUTINATION TESTS AS PERMANENT RECORDS

The appearance of satisfactory amounts of antigen and blood, and the resultant reactions of the rapid pertussis agglutination test have been depicted in various ways by color photographs as follows:

Figure 1 indicates the appearance of separate drops of blue antigen and blood when these are placed on glazed cardboard and allowed to dry without spreading or mixing. A negative reaction is shown when drops of the two reagents are mixed (a drop of antigen first being deposited, then a drop of blood being added) in the proper way as described above, and the combined drop agitated a minute and allowed to dry, thus forming a permanent record. No agglutination is seen, and the dried drop assumes a purple-like color.

Figure 2 is similar to Figure 1 with the exception that a positive reaction has resulted due to the presence of appreciable antipertussis agglutinin in the drop of blood. Agglutinated blue antigen is seen on a red background. Any appreciable agglutination of the blue antigen, as seen by direct vision in good light, is regarded as positive, and the degree of positivity may for convenience be designated as weak or strong.

Figure 3 shows the separate reagents, i.e., blue antigen and blood drops, when spread out and allowed to dry. These illustrate the appearance of optimal amounts of these reagents; however, some variation in the relative size of drops of antigen and drops of blood is not of great importance. Both a negative and a positive reaction are also included in Figure 3 for comparison of color and details.

Figure 4 shows a negative and a positive reaction which can be obtained, respectively, before and after successful pertussis immunization. These tests can be done on history cards, charts, or test protocols, and the results are directly evident as permanent records.

DISCUSSION

The sensitivity and density (about 100 billion bacteria per cubic centimeter) of the blue pertussis antigen are such that initial weak positive reactions are elicited by blood or serum having a test tube titer of 1:10 to 1:20, (or higher if the tubes are put on a shaking machine) which are usually the weakest Widal dilutions tested. Stronger rapid tests, indicated by larger clumps formed more quickly, indicate that the blood or serum is of the higher test-tube titers usually attained by successful pertussis immunization.³

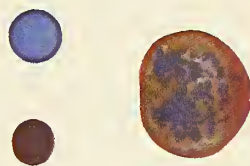
The rapid pertussis agglutination test is particularly useful for rapid assay of immunity attained in humans by prophylactic pertussis immunization. One examination of a subject is all that is needed for a test and reading, and the results are evident without delay. Furthermore, the test, on drying, becomes a permanent record needing little or no descriptive entry on the

Rapid Pertussis Agglutination Tests



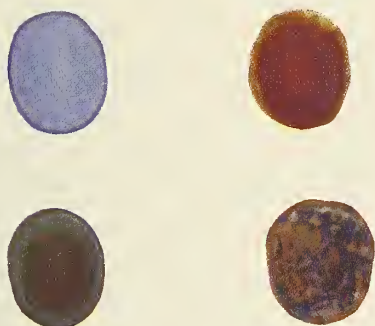
Left, above: drop of antigen
Left, below: drop of blood
Right: negative reaction

FIG. 1



Left, above: drop of antigen
Left, below: drop of blood
Right: positive reaction

FIG. 2



Left, above: antigen alone
Right, above: blood alone
Left, below: negative reaction
Right, below: positive reaction

FIG. 3



Negative
reaction

Positive
reaction

FIG. 4

COMMENTS AND EXPLANATIONS

RAPID pertussis agglutination tests in Figures 1, 2, 3, and 4 show the appearance of average amounts of blue pertussis antigen and blood when deposited alone as separate drops and also when mixed in the proper manner on white glazed cardboard in conducting actual tests.

The six separate drops of antigen and blood are shown both as unaltered drops, and drops spread out and allowed to dry in the usual way. Considerable variation in the amounts of antigen and blood used does not affect the outcome of the test appreciably, also personal preference may favor more blue or more red in the final tests.

The six actual tests including combined drops of antigen and blood as shown herewith comprise three negative reactions and three positive reactions. These reactions differ somewhat in color, depending on the ratio of antigen to blood, and the positive reactions show both large and small granules of agglutinated blue antigen on a red background.

Rapid pertussis agglutination tests may be read easily in a beam of direct sunlight or under a shaded desk lamp. Use of a reading glass may help but is not necessary for most of these observations.

records. Tests of human bloods may be made to advantage about two months following completion of pertussis immunization since agglutinins are at a maximum at this time. Pertussis agglutinins are, therefore, slower in appearance than are complement fixing antibodies, but since they persist for two to five years or more they are longer lasting than complement fixing antibodies.

The rapid pertussis agglutination test is also adapted to the assay of immunizing capacity of different lots of pertussis vaccine in Swiss mice. Groups of ten or more mice should receive subcutaneous doses of 0.25 cc., 0.25 cc., 0.25 cc. and 0.5 cc. of different lots of vaccine (containing ten billion bacilli per cubic centimeter) and these injections should be spaced at three- or four-day intervals. Two weeks after the last dose, 80 to 100 per cent of such mice on good vaccines should show strong pertussis agglutination (i.e., "scores" of 80 to 100 per cent) by the rapid test as applied to a drop of blood from the tip of the tail. Scores of 40 to 60 per cent would be considered mediocre, and scores of 10 to 30 per cent would be very poor. Certain "R" form vaccines may incite no agglutinins whatever.

Total time necessitated for this assay, including ample immunization period for the mice, is about three and one-half weeks, and the test is economical in both time and materials. Application of the rapid pertussis agglutination test to immunized mice appears more practicable than injection, either intranasally or intraperitoneally, of challenge doses of living pertussis bacilli, which may vary considerably in virulence. Furthermore,

circulating pertussis agglutinins, shown experimentally by Evans⁵ and by Anderson and North¹² to be associated with resistance to living *Hemophilus pertussis* (introduced intranasally) but heretofore troublesome to evaluate by test tube methods, especially in mice, are readily determined by the rapid test.

SUMMARY

1. The specific importance of pertussis agglutinin and agglutinogen has been reviewed.
2. The rapid test method for the determination of pertussis agglutinin has been described stepwise, and sample reactions illustrated. "Weakly positive" rapid test results correspond to test-tube titers of 1:10 to 1:20; "strongly positive" rapid test results correspond to test-tube titers of 1:40 or over. These figures are higher if tests are run on shaking machine.
3. Original records of the rapid pertussis agglutination test comprise the actual tests, which readily form a permanent record when dry. This has certain advantages over "readings" of various other tests.
4. The rapid test is useful in determining pertussis agglutinin (at about two months or later) following immunization of human subjects. It is also useful in assay of commercial pertussis vaccine; such vaccine is injected into Swiss mice, and two weeks later the agglutinin incited in each animal is determined by the rapid test.

¹² Anderson, G., and North, E. A.: The Relation of Pertussis Endotoxin to Pertussis immunity in the Mouse. *Australian Jour., Exp. Biol. and Med. Sciences*, **21**:1-8, 1943.

ABSTRACT

SULFONAMIDES ARE OF NO VALUE IN TREATMENT OF POLIOMYELITIS

The sulfonamide drugs are of no value in the treatment of infantile paralysis, and physicians should be warned against their use for this disease, John A. Toomey, M.D., Cleveland, declares in a letter published in *The Journal of the American Medical Association* for September 2. Dr. Toomey says:

"I feel that physicians should be warned against the use of sulfonamide drugs in the treatment of poliomyelitis.

"It has been noticed clinically that when paralyzes of the intestine and urinary bladder persist there are apt to be extensions of the . . . paralyzes. When urinary retention was produced in animals (monkeys) by the use of sulfonamide compounds, drugs which produced ureliths and blockage of the ureters, a more massive disease was produced two or three days sooner than that which appeared in controls simultaneously injected with poliomyelitis virus.

"Rosenow had the same experience with sulfapyridine at the Mayo Clinic and reported that this drug produced an additive neurotoxic effect.

"Recently an explosive epidemic of poliomyelitis occurred in a small town of northern Ohio. The number of patients that developed severe paralysis seemed out of proportion to the normal expectancy. Most of these patients had received sulfonamide drugs.

"Recently a twelve-year-old girl had signs of meningeal irritation, but no sign of any muscle involvement save in one leaf of the soft palate. The reflexes were hyperactive; the child was not acutely ill. . . . The prognosis seemed good whether the condition was poliomyelitis or meningitis. Sulfadiazine was started. Twelve hours later and after 12 Gm. of sulfadiazine had been given, a massive extension of paralysis suddenly developed, the throat muscles and intercostals all becoming affected within an hour. This sudden explosive extension in an otherwise nearly normal patient had not been our previous experience in this type of case.

"The sulfonamide drugs are of no value in poliomyelitis, nor does penicillin help much in our experience, although we have not noticed that it does harm."

THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA
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OCTOBER, 1944

Editorials

SOLVING MEDICAL PROBLEMS

The meeting of the Executive Committee, in conjunction with the Committee on Public Policy and Legislation, held in Indianapolis on September tenth, will go down in our records as another notable achievement. This was not a large meeting, as numbers go, but a meeting in which all "took their hair down"—those that had such a commodity—and immediately got down to business in a five-hour session. The committees first met separately, each group handling its own special problems, but after lunch there was a joint meeting.

One report always interesting to the Executive Committee was that of the treasurer, Doctor Weyerbacher, who reported that for the first time in years it would be necessary to buy a bottle of bright red ink, therewith to balance the 1944 budget. Many reasons may be assigned for this dilemma, chief of which is the fact that more than one thousand of our members are now in the armed services, hence these ten-spot bills were sorely missed—they pay no dues, as a matter of course.

After discussing much routine business, the Executive Committee joined the other group for an afternoon of very informative discussion, with Doctor Norman M. Beatty presiding. He first introduced—rather presented—Doctor J. T. Oliphant,

our President, who gave one of his delightful, informal addresses.

The guest of the day was Doctor Joseph S. Lawrence, formerly of the New York State Medical Society, now the Director of the Bureau of Publicity and Public Relations, of the American Medical Association, in Washington. Doctor Lawrence has had a long experience in this work, for years having been thus engaged by his former state organization as a consultant. It was in this capacity that he first was sent to Washington by the American Medical Association, but as of September first he became the Director of the Bureau.

This move is mighty pleasing to Hoosier Medicine, since we, along with a few other states, have consistently urged that such an office was vitally necessary in our capital city. Dr. Lawrence, having seen Hoosier Medicine at work through the earlier hours of the day, gave unstinted praise to the manner in which our committees operate. He opined that if all states were as active his present job would be materially lightened.

Doctor Lawrence has definite notions about the relation of physician and patient, in the matter of what constitutes a high quality of medical care, and stresses the point that this is one of the strongest factors in holding the American people to "our side." He declares that if we tell the public what good medical care means, then go about doing our work in just that manner, we will have gone a long way toward entrenching the profession in public favor.

He also discussed medical politics, stating that all too often we approach the matter in the wrong manner. "Do not attempt to use pressure," said Doctor Lawrence; "the days of pressure groups are rapidly disappearing." (One has but to look at a modern instance of "pressure grouping," where the collection of a vast sum of money was attempted, this money to be used to carry the election—it already is proving a boomerang.)

The Washington Medical Bureau will not be a lobby, says its director, "Rather do I propose to gather information for the medical profession than to send out that information to organized medicine. Of course, we will follow such legislation as affects the medical profession, and will keep medical organizations fully in step with what is going on."

Another bit of advice is that we should never overstate our position; we should be careful in the promises we make, and should not pledge the impossible. It is his opinion that our opponents have strongly overstated their position on various points, and thus have created much doubt in the minds of the listeners.

In conclusion, Doctor Lawrence expressed himself as having been much pleased with the manner in which our Health Insurance Committee is operating, being quite in accord with our findings.

Dr. Cleon Nafe, chairman of the Executive Committee, discussed some of the newer programs that

had been studied by his group. The Group Malpractice Insurance Program was carefully explained to those present, the many questions asked being indicative of much interest in the program that has been adopted, and which was explained in the September issue of *THE JOURNAL*.

Albert Stump, counsel for the Indiana State Medical Association, discussed some proposed changes in the Medical Practice Act, originally written by the late Doctor William Niles Wishard, in 1897. Comment on these proposed changes will be made in a later issue of *THE JOURNAL*.

The outstanding feature of the meeting, as it occurs to us, was the interest manifested by the Director of the Bureau. After all, Indiana played a prominent part in bringing this bureau into existence, and now that a full-time director is in charge we look forward to a much more hopeful outlook in Washington affairs.

OUR SMALLPOX RECORD

We have been rather complacent about the matter of smallpox in Indiana, a few cases here and there seeming not to arouse a more than casual interest among physicians, yet the record shows that Indiana is not doing so well in the prevention of this disease as most other states.

In the *Statistical Bulletin*, a publication of the Metropolitan Life Insurance Company, for May, 1944, is given a table showing the incidence of this disease in every state in the nation. Indiana occupies a most unenviable spot in this table; as a matter of fact, we are at the bottom of this list. For the year 1943 we had 37 cases per million of population, while nine states had none. The state of Ohio shared with Indiana in having "the poorest records in the country."

The *Bulletin* says, "There were 129 cases of smallpox in Indiana in 1943, or more than twice the 63 cases reported for 1942. Indiana has long been a fertile field for this disease and, although it had shown improvement, was again at the bottom of the list last year."

In a nation-wide survey it was shown that 1943 was a record low for smallpox, the total being some 11 per cent below the former year. It also is pointed out that smallpox is showing a gradual decline, save in a few states. Another interesting observation is that certain sections of America show a far less incidence of this disease than others. "The smallpox problem in this country is concentrated in a comparatively few states which form a practically continuous area, comprising the states in the Pacific Northwest, those between the Rocky Mountains and the Mississippi River, and those on the northern bank of the Ohio River."

Further observation reveals that our northern neighbor, Canada, has but little smallpox, there having been but six cases reported for 1943. And,

oddly enough, these cases were reported from two provinces that adjoin high areas of incidence in this country.

Such is the record of a communicable disease in our state, a disease that can be absolutely wiped out by the simple process of vaccination.

It not only is a problem for our boards of health; it becomes the problem of every practicing physician in Indiana. We can make a decided change in this very poor record, and it is our duty to do it, and do it now. Indiana has an enviable record in matters pertaining to health, generally, and we should no longer permit this blot upon our escutcheon.

"EXPERT TESTIMONY"

A recent murder trial in the city of Washington brought together a long array of medical expert testimony, and, as is usual in such cases, there was the pro and con element. From the newspaper reports of this trial, both parties to the shooting being professional men and the trial therefore attracting more than usual attention by the press, it was clear that this medical testimony was quite at variance. In the editorial columns of *Medical Annals of the District of Columbia*, for July, 1944, appears comment on this subject that is worth repeating, since it succinctly points out the many evils pertaining to our present conception of what medical expert testimony should be. It is printed herewith:

"A recent criminal trial in the District Court has called attention again to a perennial problem, that of expert medical testimony.

"In a criminal case the emotions of the public may run high, sides are taken, and there is a demand for vengeance by some, while others urge acquittal. In short, the trial, instead of a forum for the search for truth, becomes an arena in which the prosecutor and defense do battle, and anyone who appears as a witness is looked upon as a partisan, whatever his intentions or motives.

"The lot of the medical man, particularly if he be called upon to give an opinion concerning the defendant's 'sanity,' a medically-unrealistic concept, defined by wholly unpsychological standards laid down by legal philosophers a hundred years ago, is not a happy one. Even if he has made an examination of the defendant (and the jail or courtroom is hardly comparable with the hospital or office), he is subjected to various hypothetical questions, which, like as not, merely befuddle the jury. Further, the fact that he is produced by one side or the other makes his testimony suspect as presumably biased. It is, of course, axiomatic that a lawyer will not knowingly call an expert whose opinion is greatly at variance with the former's theory of the case.

"The Commissioners on Uniform State Laws proposed a bill about 1937, which, although a substantial advance, has not yet been adopted in toto in any jurisdiction. If the law lags in expecting progress, however, the medical profession at least have it in their power to bring about improvement by voluntary action. Consideration might well be given to a policy under which no psychiatrist would agree to act as expert unless it were stipulated that his examination should be made jointly with the

other experts employed by both parties, and that a joint report should be submitted. In this manner the testimony would deal with the same facts and much would be accomplished toward eliminating the appearance (perhaps the fact) of bias. The expert, at least, should do his part, despite any examples which may be set him, in seeking to learn and present the truth as clearly and impartially as human emotional attitudes will permit."

THE PROBLEM OF MYOPIA

For some time we had been considering an editorial on the subject of myopia, commonly termed "near sightedness." There apparently are many misconceptions regarding this condition, by many termed as a disease of the eye. In a refracting experience of more than four decades we have made several observations regarding this refractive error, many of which would seem to be at variance with others engaged in the practice of ophthalmology. We cannot agree to any extent with those who decry the importance of a proper correction of this condition, nor can we agree with the occasional statement that one with a rather high degree of error does not necessarily have to wear his correction for constant use.

Again, we are at more than a variance with the few who tell their patients that a myopic condition is a transient thing, and that in a short time the condition will right itself. In a few instances we have heard ophthalmologists decry the hereditary factor, stating they hold no "truck" with such notions.

If heredity plays no part in myopia, we might ask why certain races are prone to have this condition. The Germans, as a race, are notoriously myopic, and the same may be said of certain of the yellow races; Jewish people commonly are myopic, particularly those from certain areas in Europe. We have known four generations, here in America, to have myopia—not every member of all families are thus afflicted, but the "myopic strain" is predominant.

Of late years this subject seems to be attracting more attention than formerly; the medical press is giving more space to the discussion of the problems of myopia than in years past. New conceptions are constantly springing up, some of them with some degree of merit.

A recent article by W. T. Davis, in the June number of *Medical Annals of the District of Columbia*, affords material for much thought in this connection. The writer brings to our attention some new ideas regarding the possible cause of myopia. He goes back to the time of Bismarck, in Germany, one of whose earliest decrees was that the children of Germany must be educated. Children were sent to school at an early age; the schools were overcrowded; light and ventilation was not what it should have been—all these factors, the writer believes, had to do with the creation of a myopic race.

While we of today are not agreed as to the cause of myopia—as a matter of fact we know little about that, we are agreed that such conditions as those just described have much to do with it. We are further agreed that myopes should be on a "reading diet," and that the best of lighting conditions should prevail. We tell the parents of myopic children that the young hopefuls should not be permitted to pore over the printed page for hours at a time, and that lighting conditions should be "just so."

The author of the article in question apparently agrees with all these things, but he reaches new heights in his discussion of the problem. He seems to take his cue from visual conditions in Switzerland, where myopia is indeed a rare affliction, and he makes it clear that it is his opinion that the physical exercises which play such an important role in the schools of that nation have much to do with conditions there, visually speaking. He makes bold to state, "There is no question in my mind but that the great handicap, myopia, is preventable, and in many cases curable in youth, if children are kept out of doors and given vigorous exercise." He also decries the prescribing of glasses unless it becomes absolutely necessary, with which dictum we most heartily agree. He cites the experiences of chaps who a few years ago were moderately successful with the then popular fad whose slogan seemed to be, "Take off your classes; they are really not necessary." And, in many instances in which glasses had been prescribed when they should not have been the plan seemed to work. However, many of us refracted cases that had undergone these treatments and again prescribed glasses, as of yore.

One more quotation from the author seems imperative in this connection, "There is need for us to realize that vigor and health are more essential to the safety of the individual, the family, the community, and the nation than nonessential education."

We must agree with this, in the main; we also are constrained to wonder if, had American youth, as a body, had more hours of outdoor exercise, even though it had been gained at the expense of fewer hours in the classrooms, the Selective Service examination picture might not have been different than it is today. We are a strong supporter of our educational system, but also believe it has its shortcomings. We now see school children trudging home from their classrooms; in too many communities we see these little folk, some of them well below the 'teen age, carrying practically all their books home each night. We personally see them, little tykes of six to ten years of age, carrying almost every school book they own back and forth every day.

We cannot agree with such a program, and can only hope that these books are toted home only because it is an order from the teachers—that they are not opened during the entire evening. This should be the time for outdoor recreation;

poring over school texts, at night, should have no place in the life of children at this age. It is productive of enough ill effects among normal children; with the myope it becomes an added hazard, one that is not necessary and should not be tolerated.

We need more such enlightening discussions of myopia, such as this one by Doctor Davis. We need more and more discussion of the subject in our medical meetings, not only those of the special groups, but of the general practitioners themselves.

Editorial Notes

This issue of THE JOURNAL is a "baby edition" as compared with our last publication, but our paper quota for the year is limited, and since we exceeded our monthly allotment for the special Army Air Force and Convention Number, we must cut down on this issue.

In conformance with our custom of the past few years, it was decided that the dinner at the time of the annual convention should be an informal affair. Many members have expressed themselves as highly approving this, since wartime is no occasion to make a dressy display—medical business is the order of the day in these times.

The September number of THE JOURNAL, one-hundred-ninety-six pages, was the largest issue ever published in our history. The pre-convention number always is a bit oversize, but on this occasion we had so much material, all of which was vitally necessary, that we went over the limit. Those not immediately concerned with the preparation of material and the pre-publication work have little idea of the hugeness of the task. It means a lot of preparation and planning; it means a lot of overtime, and occasionally it means a lot of prodding to get material in reasonably early. As usual, we all are mighty proud of this number.

Every member of the Indiana State Medical Association has received a letter concerning the Group Malpractice Plan, as worked out by your Executive Committee. This subject has been under consideration for many months, many of our members having been dissatisfied with present-day malpractice insurance. The new plan provides for adequate coverage, much broader than in the average policy and at a comparable cost, with bright prospects of a reduction in premiums later on. If you have not already gone into the matter, we would suggest you study the plan as printed in the September issue of THE JOURNAL, then take immediate action.

The National Grange, at its meeting in Syracuse some time ago, went on record as follows in regard to socialized medicine:

"The adoption of such a plan would go a long way toward the establishment of state medicine in the United States, with the people being obliged to support the doctor through funds raised by taxation, and with the possibility that eventually the taxpayers would in some degree, at least, be deprived of freedom of choice in the selection of their physicians. However, we look with favor on various voluntary plans for group medical care that are now in operation throughout the country."

The *Kentucky Medical Journal* paid a merited tribute to its long-time editor, Doctor Arthur T. McCormack, in dedicating its August number to his memory. The editorial comment reflected the various achievements of this good man and his contributions to the health of his native state. Comments were cited from several medical journals over the country, for this man had a nation-wide acquaintance, as did his eminent father who for many years had served the Commonwealth of Kentucky as its chief health officer. Kentucky Medicine has done itself proud in the formal recognition of the work of both father and son in building a health structure that long will survive.

"Tropical Diseases" continue to be the theme of much comment in the daily press, it being recognized that with the return of our soldiers from every corner in this big World, it is certain that some of these infections will be brought into the country. Quarantine regulations will, of course, have to be stepped up after the war, but we cannot very well quarantine all of our returning soldiers. It also will mean that in some of our southern camps, where millions of dollars have been spent in drainage projects to lessen the incidence of malaria, these preventive measures will have to be continued. The tropical disease problem long will be a factor to be considered in the future health of our nation.

The *Journal of the American Medical Association*, for September second, carried an article of great interest, in the report of the cure of a case of cavernous sinus thrombophlebitis through the use of penicillin. From the excellent description of the symptoms and findings in this case there can be no doubt as to the correct diagnosis. This disease long has been deemed incurable, although in recent years the sulfa drugs have been credited with a few cures, but it seems that these failed in this case. Penicillin was administered both intravenously and intradermally, although in the latter stages the intradermal method was used exclusively. In the reported case there was complete loss of vision in one eye.

After a long-continued discussion of the matter, the Indianapolis Medical Society has decided to employ, in the near future, a full-time, lay secretary. We often have wondered why this action was not taken years ago, having had no little experience in such a venture in our home society these past five years. The Indianapolis group is to be congratulated on this move, and we feel certain that the entire membership will highly approve thereof, once the machinery gets into operation.

During our vacation this summer we noted an apparent increase in the number of wood ticks. One day when we had pulled in to shore to prepare lunch, one of the men in the party laid down on a bunch of small shrubs. A little later he found several of the ticks on his face and neck. Other reports are to the effect that the ticks are commonly found in sections of our own state, and some cases of Rocky Mountain spotted fever have been reported here. Just another of the many precautions to be taken, and for which we have to be on a constant lookout.

Some of us oldsters, chaps perilously near the "three-score-and-ten" mark, have been patting ourselves on the back because we are still going strong, doing our level best to further the war interests, when along comes a newspaper story of a southern Indiana physician who makes us take a back seat. Doctor M. P. Hollingsworth, aged eighty-two years, maintains his regular office hours and still attends to the needs of a considerable portion of the population of that community. He has the unusual distinction of having made physical examinations of soldiers in the last three wars in which this country has been engaged, plus a long service on the old-time pension board for that area. He has been located in Princeton for more than fifty years, having practiced in his native Marion County prior to that time. Although he takes things a bit easier these days, he still manages to do his war bit, keep abreast with his books and, as the news-story goes, enjoy the companionship of his dog.

Our September number finally reached your desk, even though it was almost two weeks late. In explanation, we may say that this is the largest number we ever have printed, almost two hundred pages. It carries full committee reports, convention program and announcements, and a host of good scientific articles. With the limited force at the office of THE JOURNAL, it is no mean task to get up the average volume, but when we double about everything it becomes a *real job*. We trust that we may be pardoned for being inordinately proud of this production; to our notion it really is *tops*. It is a complete cross section of Hoosier Medicine for the past year; one who reads this number from cover to cover will have a first-rate idea of just what is being done in Medical Indiana. We take our hat off to no other state in the matter of medical accomplishment, nor in the matter of the production of a medical magazine.

It seems that some of the other medical journals are experiencing the same sort of delay as are we, all of which is, of course, due to wartime conditions in the print shops, and which also affects our office. In the current number of the *New Orleans Medical and Surgical Journal* the editor takes occasion to apologize to its readers for its being late in reaching their desks. Medical editors are not complaining about this, merely explaining to the various memberships just why these delays occur. One thing that pleases us, however, is that when the magazine finally *does* get in the mails, there is no sign of a let-down in the quality of the mechanical product. We continue to be very proud of the appearance of our JOURNAL.

Practically every week *The Journal of the American Medical Association* publishes a list of fraud orders issued by various governmental agencies against drug and patent medicine manufacturers. We regularly read this list, finding therein several names well known to us, and often have wondered just what would happen if some manufacturer "forgot" the governmental warning. The answer seems to be found in a news note concerning a New Jersey resident who had had such an order issued to him, but it seems that he was a persistent cuss, so carried on his advertising as usual. Well, the Federal Trade Commission again caught up with him, and when his case had been heard in court he received a fine amounting to the sizeable sum of \$5,000.00, probably enough to make him sit up and take notice.

At long last the American Medical Association has acceded to the demands made by many state societies that a Washington office be opened and maintained. The plan at first contemplated having Dr. Joseph Lawrence, of New York, as consultant; he was to spend part of his time in that work. However, it was learned that this was not just what was needed. Justifiable complaints were made that this was of the make-shift order, and that what was needed was a full-time man who knew what it was all about.

As of September first, Doctor Lawrence became director of this bureau, a choice that we believe will meet with the approval of most of our state organizations. Doctor Lawrence has had a valuable experience in this sort of work in his home state, and brings to the new office just what is needed to give us adequate representation in the National Capital.

As he has stated, it is not his plan to serve as a lobbyist; rather does he expect to keep in touch with all that goes on that in any way is of interest to the profession, and to report his findings to organized medicine. The "Washington Letters," in the *Journal of the American Medical Association*, will be of added interest from now on, we are certain.



President's Page



The State Board of Medical Registration and Examination is the agency through which the State of Indiana regulates the practice of medicine within its borders. In defining the duties of the Board, the law of 1897 says:

"The State Board of Medical Registration and Examination shall, from time to time, establish and record in a record, kept by them for that purpose, a schedule of the minimum requirements which must be complied with by applicants for examination for license to practice medicine, surgery, and obstetrics before they shall be entitled to receive such license. The said Board shall also, in like manner, establish and cause to be recorded in such record a schedule of the minimum requirements and rules for the recognition of medical colleges, so as to keep these requirements up to the average standard of medical education in other States."

The Board has the right to establish reciprocity. "It shall have the power to make and establish all necessary rules and regulations for the reciprocal recognition of certificates issued by other States, and to prevent unjust and arbitrary exclusion by other States of graduates in medicine from this State who have fulfilled its requirements."

Further provisions of the law gives the Board the right to revoke the license of anyone who has obtained it by fraud or misrepresentation, or who is guilty of felony or gross immorality, or who is addicted to the liquor or drug habit to such a degree as to render him unfit to practice medicine or surgery. It may also refuse to grant a license to anyone guilty of these offenses. No one shall be permitted to practice medicine without first obtaining a license from the State Board of Medical Registration and Examination, and the Board is given full power to prosecute all violations of the law. The attorney general of the state and the prosecuting attorneys of the counties are charged with the duty of conducting any legal action the Board may see fit to bring.

From reading these brief provisions of the Medical Practice Act, the importance of the State Board of Medical Registration and Examination becomes evident. This Board has the sole responsibility of fixing and maintaining the standards of medical practice in Indiana. Whatever may be our criticism of any individual members who have served on this Board, or whatever may be our criticism of any specific actions of the Board, we must admit that the present standard and quality of medical practice in Indiana are as good as any to be found in any other state in the Union. In the achievement of this result, our State Board has been under the constant handicap of a chronic lack of funds. Many violations have not been prosecuted because there was no money with which to procure necessary evidence. The only revenue to support this Board is derived from the fees paid by applicants for license. This fee is fixed by law at twenty-five dollars. For many years this income has been sadly inadequate. Some steps should be taken to increase the available funds, either by a registration fee paid annually by all practitioners, or by a larger fee to be paid by candidates for licensure. A license to practice medicine is a property right, a right that gives the holder an opportunity to exchange his training and skill for cash. The holder of such a privilege should be willing to pay a sufficient fee to support the state agency that defends and protects him in his right to practice.

The men who serve on the State Board do so at a great sacrifice of time and money. The salaries of the members, as fixed by law, is six dollars per day for the time actually spent in attendance at the meetings of the Board, with an allowance of four cents per mile for traveling expenses. For a doctor who lives outside of Indianapolis this represents a considerable loss of revenue during the year. In spite of this, good men have always been willing to serve, and over the past years the Board has functioned well. Hundreds of unfit and unqualified practitioners have been kept out of Indiana, and other hundreds who have abused their privilege of a license, or who have sought to set up without a license, have been driven out. If the activities of the State Board of Medical Registration and Examination were to be suspended for six months we would be overrun with such a horde of undesirables that it would take years to clear them out.

The argument that medical societies can protect themselves by exercising the functions of the State Board is untenable. This method was tried during the years from 1816 to 1897, and was unsuccessful. Only by supporting the state department, which has cooperated so well in the effort to regulate the practice of the healing arts, can high standards be maintained in the future.



REPORTING OF OCCUPATIONAL DISEASES TO THE INDIANA STATE BOARD OF HEALTH, FOR A THREE-YEAR PERIOD ENDING JUNE 30, 1944

LOUIS W. SPOLYAR, M.D.*
INDIANAPOLIS

Within the three-year limit specified, physicians of Indiana have voluntarily reported a total of 1478 occupational diseases. These reports are absolutely voluntary, for Indiana does not have a law requiring the reporting of such diseases to the Indiana State Board of Health. As of May, 1944, when Mississippi adopted its regulation requiring the reporting of occupational diseases, twenty-five¹ states have passed regulations requiring such reporting to their respective state boards of health. A listing of all the states where reporting is mandatory can be found in Fowler's² report on "The Reportable Diseases." The purpose of either voluntary or mandatory reporting is to gather statistical data on the incidence of occupational diseases in order that outbreaks can be localized and studied, and preventive measures instituted. At no time should these reports and studies be used as a basis for medico-legal disputes by the State Board of Health. Such use merely hinders reporting and therefore decreases the amount of prevention.

In order to visualize which occupational diseases are prevalent in Indiana, the reports for the last three years were tabulated.

(A) From Table I it is quite apparent that by far the predominant occupational disease in this state is industrial dermatitis. Of the 1478 occupa-

Phosphene Inhalation	1	.....	1
Hydrofluoric Acid Inhalation.....	1	.....	1
Typhus Fever	1	.....	1

tional diseases reported, 1281 cases, or 86.6 per cent, were some type of industrial skin disease. For the country as a whole industrial dermatitis accounts for about 65 per cent of all the occupational diseases reported.

(B) In order to visualize what industrial skin diseases have occurred during this three-year period, Table II was prepared. A summary of Table II reveals that eighty different entities have been reported as causing an occupational dermatitis. Further, it is quite apparent that cutting-oil dermatitis is Indiana's number one industrial skin disease, for of the 1281 cases of dermatitis, 479 cases, or 37 per cent, were due to cutting oils. The prevention of cutting-oil dermatitis looms as one of medicine's great industrial medical problems. Toward this end much has been written as to the etiology, treatment, and prevention of cutting-oil dermatitis; however, for those interested in this problem the writer refers them to an excellent paper on this subject by Dr. Samuel M. Peck.³ Dr. Peck clearly and logically outlines the steps necessary for the prevention and control of this disease.

TABLE I
OCCUPATIONAL DISEASES REPORTED TO THE INDIANA STATE BOARD OF HEALTH FOR A THREE-YEAR PERIOD ENDING JUNE 30, 1944

Diseases Reported	1941-1942	1942-1943	1943-1944	Cumulative
				Totals
Total	360	490	629	1478
Industrial Dermatitis	310	439	533	1281
Epidemic Keratoconjunctivitis.....	.....	.....	34	34
Acetone Absorption .....	.....	.....	24	24
Lead Absorption .....	.....	4	18	22
Lead Poisoning	16	6	.....	22
Carbon Monoxide Poisoning.....	1	20	.....	21
Silicosis	9	6	1	16
Hydrogen Sulfide Inhalation.....	12	.....	.....	12
Silico-tuberculosis	4	4	3	11
Cadmium Poisoning .....	.....	.....	9	9
Metal Fume Fever (Zinc).....	3	1	4	8
Solvent Absorption .....	.....	7	.....	7
Selenium Poisoning .....	.....	.....	3	3
Carbon Tetrachloride Poisoning	2	1	.....	3
Methyl Chloride Poisoning.....	2	.....	.....	2

* Director, Division of Industrial Hygiene, Indiana State Board of Health.
¹ *Industrial Hygiene News Letter*. U. S. Public Health Service, 4: June, 1944.
² Fowler, William: The Reportable Diseases, *Public Health Reports*, 50: (March 10) 1944.

TABLE II
BREAKDOWN OF THE 1281 INDUSTRIAL SKIN DISEASES REPORTED TO THE INDIANA STATE BOARD OF HEALTH FOR A THREE-YEAR PERIOD ENDING JUNE 30, 1944

Dermatitis Due to	1941-1942	1942-1943	1943-1944	Cumulative
				Totals
Totals	310	439	533	1281
Petroleum Oils and Greases (Total 490)				
Cutting oils	15	154	310	479
Chlorinated cutting oils.....	9	.....	.....	9
Grease .....	.....	2	.....	2
Chlorpernapthalene	181	.....	.....	181
Explosives (Total 138)				
Tetryl	24	67	17	108
T.N.T.	3	17	1	21
Black Powder	4	3	.....	7
Lead Azide .....	.....	1	.....	1
Mercury fulminate	1	.....	.....	1
Vegetables (Total 88)				
Carrots	8	60	8	76
Corn .....	.....	.....	6	6
Tomatoes	1	3	1	5
Celery .....	.....	.....	1	1
Solvents (Total 59)				
Solvents (N.O.S.*)	4	10	9	23
Naphtha .....	.....	8	.....	8

³ Peck, S. M.: Dermatitis from Cutting Oils, Solvents, and Dielectrics, *J.A.M.A.*, 125:190-196, (May 20) 1944.

Dermatitis Due to				Dermatitis Due to			
1941-1942	1942-1943	1943-1944	Cumulative Totals	1941-1942	1942-1943	1943-1944	Cumulative Totals
Mineral spirits	5	1	6	Solder (Tin and Lead).....		1	1
Gasoline	3	2	5	Selenium		1	1
Carbon Tetrachloride	1	1	2	Gold		1	1
Trichlorethylene		2	3	Five-cent coin	1		1
Benzol	1	1	2	Fish Oils		6	6
Varisol		2	2	Smallpox Virus		5	5
Turpentine	1	1	2	Thiamin Chloride	3		5
Stoddards		1	1	Cement Dust	2	2	5
Alcohol	1		1	Emery Dust		2	4
Toluol	1		1	Cutting-oil Antiseptics		3	3
Textiles (Total 58)				Tin Cans	2	1	3
Anti-mildew agents	1	25	26	Rock Wool		3	3
Dyes	6		14	Calcium Chloride	2		2
Textiles (N.O.S.*).....	7	5	12	Rosin	1	1	2
Wool cloth		2	2	Talc		1	1
Synthetic Resins	3	35	46	Phenol		1	1
Rubber Antioxidants	9	7	31	Soap		1	1
Acids (Total 26)				Molding Compound		1	1
Acids (N.O.S.*)	3	13	16	Eggs		1	1
Chromic Acid	10		10	Leather		1	1
Wood and Wood Working (Total 17)				Felt		1	1
Wood (N.O.S.*)	1	2	3	Sporotrichosis		1	1
Varnish	3		3	Candy		1	1
Paint	2		2	Water		1	1
Cedar	2		2	Flour	1		1
Evergreen		2	2	Spun Glass		1	1
Pine		1	1	Leather	1		1
Maple	1		1	Graphite		1	1
Hickory		1	1	Causes not stated	13	12	25
Linseed Oil	1		1				
Furniture Stain		1	1				
Glues (N.O.S.*)	5	4	17				
Anti-rust Compounds			18				
Alkalies (Total 15)							
Alkalies (N.O.S.*)		2	11				
Sodium cyanide		2	2				
Caustic soda	1		1				
Slaked lime	1		1				
Metals (Total 15)							
Copper	5	1	7				
Brass	1	1	3				
Iron		1	1				

* (N.O.S.) not otherwise specified.

SUMMARY

- (1) A total of 1478 occupational diseases were reported to the Indiana State Board of Health for a three-year period ending June 31, 1944.
- (2) Occupational dermatitis accounts for 86.6 per cent of all the cases reported.
- (3) Cutting-oil dermatitis ranks as Indiana's number one industrial disease, accounting for 37 per cent of all the skin diseases reported.
- (4) The prevention and control of cutting-oil dermatitis becomes one of the major industrial tasks of Indiana Medicine.

Deaths

George Grant McConnell, M.D., of Mooresville, died August eleventh at his home. He was seventy-eight years of age. Doctor McConnell was a graduate of Rush Medical College in 1892. He had retired from practice.

Bertis Charles Gwaltney, M.D., of Fort Branch, died August tenth following a short illness. He was fifty years of age. Doctor Gwaltney graduated from the Indiana University School of Medicine in 1930, and had practiced for the past twelve years at Fort Branch. He had served as Gibson County health officer for the past seven years. Doctor Gwaltney was a member of the Gibson County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Charles Nicholas Stroube, M.D., of Roachdale, died suddenly at his office on September seventeenth, aged seventy-seven. He had practiced medicine in Putnam County since graduating from the University of Louisville School of Medicine, in 1897. He was a member of the Putnam County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Charles Ati Morgan, M.D., of Indianapolis, died suddenly on August thirty-first, at the age of sixty-seven. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1902, and had practiced medicine in Indianapolis for thirty-nine years. He was a member of the Indianapolis (Marion County) Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.



Military News



Major Richard S. Bloomer, of Rockville, is in England. He is on duty with a general hospital.

Now serving overseas with a hospital train is Major Frederick W. Buechner, of South Bend, who was formerly stationed at Fort Custer, Michigan.

Captain Basil K. Byrne, of New Albany, now has a New York A.P.O. address. He formerly was at Pope Field, North Carolina.

Formerly at a San Francisco Fleet post office address, Lieutenant Robert O. Bill, of Indianapolis, is now stationed at the Naval Hospital at San Diego, California.

Captain Stuart R. Combs, of Terre Haute, is stationed at Wakeman General Hospital, Camp Atterbury, Indiana. He formerly was at Fort Hayes, Ohio.

After having been stationed at Louisville, Kentucky, Major Joseph C. Dusard, of Bedford, now has a New York, Army post office address.

Lieutenant George W. Cooper, of Michigan City, has been transferred from Bethany College, West Virginia, to the Veterans Bureau Hospital at Atlanta, Georgia. Lieutenant Cooper is with the Navy.

A recent V-mail letter from Captain Frederick Dettloff, of Cloverdale, says: "Since the end of last year I have been working in the department of neuropsychiatry of a large hospital in the Hawaiian Islands."

Lieutenant Colonel A. N. Ferguson, of Fort Wayne, is quite happy with his assignment at the Oliver General Hospital, Augusta, Georgia. Colonel Ferguson is doing internal medicine.

Captain Floyd L. Grandstaff, of Decatur, has been taking special training in the chemical warfare service at Edgewood Arsenal, Maryland.

We are informed that Dr. John J. Flick, of Indianapolis, is now a captain. Captain Flick is with the Army Air Forces at Patterson Field, Ohio.

Casper Harstad, M.D., of Rockville, has been promoted to a major. Major Harstad is group surgeon at an Air Force fighter-bomber base in the European theatre of operations.

After leaving Fort Dix, New Jersey, Lieutenant Colonel Harold J. Halleck, of Winamac, has gone overseas.

On June seventh Captain N. W. Hatfield, of Indianapolis, was wounded while stationed on Biak Island, and is now in a hospital in New Guinea.

As indicated by his New York A.P.O. address, Captain James F. Openshaw, of Goodland, has left Tobyhanna, Pennsylvania, for overseas duty.

Captain Richard E. Gery, of Lafayette, has gone overseas, as indicated by a change-of-address card. He was formerly stationed at Camp Stewart, Georgia.

The War Department has announced the promotion to major of Dr. William L. Sharp. Major Sharp is stationed at Camp Maxey, Texas.

Lieutenant W. H. Nutter, of Rushville, is located at the Baxter General Hospital, in Spokane, Washington.

Captain Loren H. Martin, of Indianapolis, was assigned as squadron surgeon with the Army Air Forces Medical Corps upon his arrival in England.

As an executive officer at LaGuardia Field, Major Milo O. Lundt, of Elkhart, has supervision of the wounded and sick from the European war theatre who are flown to this country by large planes of the Air Transport Command.

Another Indiana physician at LaGuardia Field, New York, is Captain Richard C. Miller, of Indianapolis. Captain Miller was transferred there from Bowman Field, Kentucky.

Captain J. Lawrence Sims, of Indianapolis, recently spent a short leave in the city. He is stationed at the Dispensary at Selfridge Field, Michigan.

Major Frank W. Ratcliff, of Lafayette, has been the chief anesthetist at the hospital at the embarkation port at New Orleans. He now has been transferred to the Vaughn General Hospital, at Hines, Illinois.

In a recent letter, Commander Harold E. List, of Marion, states: "Technically, I am the senior medical officer and flight surgeon aboard the ———. It's a long cry from 'It's a boy!' to 'Ship ahoy!' but one soon learns." He concludes his letter by saying, "So good buy, and so are Bonds."

Captain E. B. Boyer, who was at Sunnyside Sanatorium, at Indianapolis, prior to entering service, is now serving with a division which recently landed on an island in the Palau group.

After spending more than two years in New Guinea, Captain Herman T. Combs, of Evansville, is now taking a nine weeks' course in flight surgery at the School of Aviation Medicine, Randolph Field, Texas. The trip back to the United States took only three days, being made by air. Captain Combs has now fully recovered from shrapnel wounds received while on duty in New Guinea.

Writing from France, Lieutenant Colonel Joseph H. Clevenger, of Muncie, says: "Major Henry Faul is a hospitalization unit commander of this outfit. He is from Evansville. Charles Richardson, of Rochester, and Kemper Venis, of Muncie, are in evacuation hospitals not too far away. I hear that the Indiana unit is here, but haven't seen them since leaving England.

"Our outfit arrived on D plus 2, and was the first field hospital to function on this beach. Other medical installations were here, but we were the first field hospital properly designated as such.

"We of the medical profession need not be ashamed of the part we have had the privilege of playing."

As a regimental surgeon with the First Marine Division, Commander Pierce MacKenzie, of Evansville, was recently awarded the Presidential Unit Citation in a ceremony at the United States Naval Hospital in Oakland, California, where he is now stationed. The citation was for the division's "outstanding gallantry and determination in successfully executing forced landing assaults against a number of strongly-defended Japanese positions . . . completely routing all the enemy forces and seizing a most valuable base and airfield within the enemy zone of operations in the South Pacific Ocean." The places mentioned were Tulagi, Gavutu, Tanambogo, Florida, and Guadalcanal, and the British Solomon Islands. Hats off to Commander MacKenzie!

A letter recently received from Lieutenant Colonel William B. Sigmund, of Columbus, reads as follows: "My rambling around has taken me to Australia, New Guinea, and to my present location, the Admiralty Islands. The campaign here was exciting, at least to me, and the unit I am with established a very good reputation. There are several Indiana men here — Melvin Lichtenberg, Charles George, and Leo Nonte, of Indianapolis. In nearby air units I see Voris McFall, of Anderson, and Charles Cook, of North Manchester. Also recently met Wilson of the *Indianapolis News*.

"The state JOURNAL has reached me quite regularly and I enjoy perusing it a great deal. We are all anxiously awaiting *that day* when we can get 'Back Home Again in Indiana.'"

Since entering the Army in May, Captain William E. Jenkinson, of Mount Vernon, has done considerable traveling, having been at Carlisle Barracks, Stark General Hospital, Fort Bragg, and now Camp Breckenridge, in Kentucky. Captain Jenkinson is the venereal disease control officer for the entire post.

Captain Henry J. Zimmer, of Mishawaka, is back in Syracuse, New York, and is chief of X-ray at the Station Hospital there. It seems that since leaving there two years ago Captain Zimmer has helped to build and reopen several hospitals, but he states that it would be more to his liking to tear down some in a hurry so that he could come home.

"THE JOURNAL gave me a life that I didn't know existed," is the way Captain James R. Ware, of Andrews, now serving in New Guinea, concluded a letter he addressed to THE JOURNAL Office. (Captain Ware, your letter also gave us a "lift," making us feel that our efforts are worth while, and we are sure that your fellow members will also enjoy your letter.) We take the liberty of quoting it in our columns:

"Always on the eve of tremendous undertakings and the preparations involved comes that pleasant interlude. So it happened today. I received a box of cigars from my wife, and a copy of Hoosierdom itself, THE JOURNAL.

"I leafed through the advertisements slowly, and was startled to find that back home an M.D. was actually required to practice medicine. When I read the date and the articles, even my hay fever came back just a little. Hoagy was right when he said, 'I Can't Get Indiana Off My Mind.'

"But when I reached the 'Military News' the world became a very cozy place. Most of the men mentioned were familiars and a few very good friends. I saw Stellner and Arnold at Milne Bay while attending the S.W.P.A. Malaria Control School. Balsbaugh, Cook, McFall, and Cripe I have not been able to locate in this area, although we have been in close association with service squadrons and bomb groups on our front-line missions.

"Recently, I received a letter from Colonel William S. Middleton, who is chief of the Medical Service in the European Theatre. He related his joy in Cy Clark and Don Wood, and their efforts. Some time ago I had occasion to visit the . . . Station Hospital, and learned that I had just missed Brownning, who was something or other in the medical service. He had just moved up—gossip was divided between Finschhaven, Hollandia, Nadzab, Lea, and Aitape. We haven't heard of him since although we've looked along the way.

"We are all due to get our feet wet at some time or other, and many of our boys have gotten religion without going to church. All the news is good now. We know that Indiana is helping, and that the squirrel and pheasant seasons will be rolling around, even as now, when we come home."

After being on duty for the past five months on an attack transport, Lieutenant Harry V. Scott, of Fort Wayne, is soon to be transferred to the United States Naval Hospital at Chelsea, Massachusetts.

In a recent letter Major Charles J. Cooney, of Fort Wayne, tells us that he has been transferred from Columbia, South Carolina, to Barksdale Field, Shreveport, Louisiana. He further states, "I am chief of the Urological Section in this Regional Hospital, and believe it will be a pleasant place to be on duty, but, like all other doctors in the service, I am hoping for early victory and a return to civilian practice in Fort Wayne."

Captain William H. Norman, of Indianapolis, who went over with the Indiana unit, transferred some time ago to a station hospital located in England. Captain Norman has charge of all orthopedic cases in this hospital and writes his friends that he and his assistants have been extremely busy. This unit has been under the fire of robot bombs frequently, and this has added to the tension of their service. Captain Norman writes that they have had some exciting and hazardous experiences.

Captain Oliver M. Hitch, who entered service immediately after completing his internship at the Indianapolis City Hospital, has been awarded the Bronze Star Medal, and also the Combat Infantryman Badge for his service in the Italian campaign. According to the citation, Captain Hitch, who is an assistant battalion surgeon, worked long hours under fire without regard for personal comfort. The campaign covered the advance from the Anzio beachhead to Rome.

FORT BENJAMIN HARRISON STATION HOSPITAL AND BILLINGS GENERAL HOSPITAL MERGE

The Surgeon General's Office has announced the merging of the Fort Benjamin Harrison Station Hospital (Fort Benjamin Harrison, Indiana) with the Billings General Hospital. The dispensary will be in the charge of Major S. T. Sternberg, M.C. Billings Hospital will take care of dispensary cases requiring hospitalization, which will be transferred to the jurisdiction of Colonel Harry L. Dale, M.C., commanding officer of the Billings Hospital.

Lieutenant Colonel Robert D. Howell, of Indianapolis, gives his address as "somewhere in New Guinea" in a letter to THE JOURNAL, and says: "The climate here is similar to that of Mississippi except that there is lots more of it—but they have to fight the war somewhere, and it is seldom in a popular location.

"Our neighbors are fuzzy-wuzzies, and are a very primitive people—quite able, though, to adopt the commercial side of civilization, if not its sanitation.

"I ran into James Browning, of Indianapolis, and Phillip Yunker, of Evansville, recently."

Lieutenant Robert M. Hansell, of Indianapolis, has left Camp Grant for an overseas destination. He now has a New York APO address. Lieutenant Hansell is on duty with a general hospital.

According to the *St. Joseph County Service Bulletin*, the latest news of Major W. L. Spalding, of Mishawaka, is that Burma, where he is stationed, is a God-forsaken country. He implied that it was a wise move on God's part, and we mortals might do well to follow him. The *Bulletin* goes on to say, "He has a nice, deep fox-hole and doesn't get mail often, so that really tells a long story in a few words."

An interesting note on rationing comes from Captain Don E. Kelly, of Indianapolis, who does not reveal his present whereabouts. "Our situation is as follows, and is ample for these parts: eight packs of cigarettes a week, one bar of candy, and recently, a bottle of coke. Toilet articles are sufficient. Spiritous beverages are limited to local and poor beer, and the amount is less than one bottle a day. So far I have had one bottle, and that speaks for itself."

The *St. Joseph County Bulletin* included excerpts of several interesting and informative letters written by Major George F. Green, of South Bend. We quote, in part, from *The Bulletin*:

"We have had only one alert since D-Day, and that provided no excitement at all. I saw a raider shot down a few weeks ago. It is hard to realize that it isn't just a movie, except when they get too close. Our twilight extends until 11:30 now. Seems strange to have only about four hours of darkness. Weather is still cool, and our wool clothes are comfortable most of the time.

"Was up helping admit a trainload of boys the other night, during the entire dark hours. Speaking of casualties, it is amazing to me to see how wonderfully they have been cared for at the front. We have had great luck with our rather large number of bad ones. Our whole staff has turned out O.K., thank goodness! Haven't had a twenty-four hour pass since I left home in February. The travel limit is still twenty-five miles. You get sort of used to sticking on the job constantly after a while.

"I've done several interesting blood vessel operations lately with good results. I'm able to do enough surgery myself to keep in practice nicely. We are really busy. We get patients by air evacuation, as many as five hundred in twenty-four hours at times, and many are really bad. Our fracture wards are something to see. All right-leg fractures are in traction on the left side, and left-leg fractures on the right side. You can stand at the end of the line and see the splints in perfect alignment. Our mortality record still stands at one; how, I don't know. Some of the boys are certainly on borrowed time. All of us work practically all the time, but that is good for us. Was over at our Club for a while and indulged in two glasses of cider, quite a wild night! You must try the cider and beer here sometime. It's really amazing! They couldn't give it away at home.

"You probably have a better over-all picture of the war than we do. The boys coming here have a narrow view, and it must have been really tough going in places. One came in on a stretcher wearing a wrist watch, 'Made in Germany.' He was doing all right until one sniper nicked him. Most of the patients come in directly by air evacuation."

We recently received the following letter from Captain O. R. Wilson, of Shelbyville: "I see that my address is a little behind schedule, so I will put you up to date. We have been on the move so much during the past few months that it was useless to attempt to keep you informed. We seem to be fairly permanently situated now, but, as usual, that is undoubtedly an illusion that will be shattered one of these fine days.

"THE JOURNAL is a wonderful thing for us who are out in the far reaches of the world. It has all the attributes of a personal letter from our friends in other places. We also at times are able to locate some other Hoosier in the neighborhood through the information which we find in your news of the doctors in service.

"We have a nice little hospital here in our little grove. It has been a very good place to be, and we have had plenty of work, too. I have been able to do a little surgery for the first time since I've been in the Army, and that has helped a lot to relieve the monotony of being in such an isolated spot. [His exact location can not be published because of censorship regulations.]

"Again let me thank you for THE JOURNAL which has followed me so faithfully around the Pacific for the past two years. Perhaps next year we will all be back in Indiana and can enjoy the state meeting again and as we never did before."

(Captain Wilson, we share with you in anticipating such a meeting, and can assure you that it will be a gala day for us as well as for you.)

A news release was sent to us by Captain Arthur A. Engel, Public Relations Officer, United States Marine Corps, concerning Lieutenant Max Richard Long, who graduated from the Indiana University School of Medicine in 1940, and who interned at the Indianapolis City Hospital. The story was written by Second Lieutenant Jim G. Lucas, formerly of the *Tulsa Tribune*, a Marine Corps Public Relations Officer:

"Saipan, Marianas Islands—(delayed)—"This is the most beautiful thing I have ever seen."

"There was no beauty in what he actually saw. The beaches were lined with the broken bodies of men who had been whole when they awoke at dawn. There was blood and death amid the constant rumble of heavy artillery which the enemy poured down from the hills.

"Beauty lay in the speed with which these damaged bodies were pulled back from the mounting fury of battle; the quiet, orderly precision with which heroic doctors and corpsmen, trained for peace but tempered in war, mocked the confusion and chaos which swirled about them; the unwavering demands of a creed which caused men to risk—and often to lose—their own lives to save that of a stranger.

"Major credit for conduct of one of the most successful evacuation stations on Saipan's bloody beaches is given Lieutenant Max Long, a Navy doctor, of Marion, Indiana.

"Assisted by Lieutenant (jg) Charles B. Mueller, of Carlinville, Illinois, Dr. Long came ashore four hours after the first Marines had come to Saipan, and remained on the beaches, frequently under heavy shellfire, to evacuate the wounded until hospitals could be set up ashore. The story of Drs. Long and Mueller is a story which can only be had by talking to others who saw them work.

"Doctors and corpsmen swarmed over amphibian

tractors as soon as they arrived from the front, administered blood plasma to two of the more seriously hurt, set splints for a Marine whose arm had been shattered, and had the tractor in the surf, headed back to the transports, five minutes later. Many times Marines, caught by enemy shells deep in fighting territory, are on the operating table aboard a hospital ship three hours later. More than five hundred wounded men were taken off Saipan from Dr. Long's evacuation station alone in the first twenty-four hours of the battle; 1,050 in the first four days.

"Drs. Long and Mueller were chosen by Naval Commander W. C. Baty, of Bessemer, Alabama, chief surgeon for the Marine Division, to man an evacuation station 'until we capture enough soil to safely set up field hospitals.' With them went twenty hospital corpsmen and ambulance drivers, at least one of whom paid with his life in performance of his duty.

"Dr. Long set up his station near a road junction at the beach, ignoring the obvious danger that enemy guns undoubtedly would register upon any concentration of traffic. His reason: Here would be the best chance to collect wounded as they were brought back to the front, and to find transportation for them out to sea. Enemy shells peppered the area. A nearby aid station was hit, killing several wounded. Dr. Long said, 'I guess we were lucky.' He escaped with a score of near misses.

"Navy Ensign Frank Alderman, of Arlington, Virginia, described a visit to Drs. Long and Mueller:

"Shells began coming close, and Dr. Long yelled at me: 'Better get out, they're aiming at us!' I assumed he'd go with me. I took his advice and made fast time down the beach. I looked back to see Dr. Long climbing aboard a tractor, directing his men in loading the wounded. As he stood there, shells were bursting in the water only a few yards in front."

"Commander Baty said he frequently saw Dr. Long moving about on the beach, caring for the wounded during the fury of an enemy shelling. 'Quite often,' Commander Baty said, 'He was the only man out of his foxhole.'

"Wounded Marines were usually given First Aid treatment on the line, but the ride across the rough Saipan terrain had in some cases caused a relapse. Upon Dr. Long's decision depended, in many instances, life and death. Before the majority of them could be sent out across the reefs, he and his men gave them new injections of morphine for relief of pain, and new sulfa dressings. Without it they would not have survived.

"Most punishing was the necessity of deciding which man had the best chance of survival, for sometimes there was not enough room in the tractors for all the wounded waiting on the beach. It was often Dr. Long's duty to order the removal of one man to make room for another. Those left behind were certain to die on the rough ride across the reefs—men with only a few minutes of life left in their bodies. In all, more than thirty Marines died on the beaches, despite efforts of the doctors to save them.

"Dr. Long paid high tribute to the amphibian tractor battalions, the 'ducks' and the hospital jeeps. Many of the drivers were killed while assisting in pulling back the wounded. Frequently at night wounded were brought in, and were kept at the evacuation station until the boats were brought in at dawn. It was impossible for the doctors to sleep. If lives were to be saved, constant vigilance was required. In addition, enemy shelling killed and wounded scores of men in the area of the beach evacuation station, all of whom were treated on the spot. Some were so hopelessly wounded that evacuation was impossible.

"Dr. Long said his ambulance drivers went so far beyond battalions aid stations at the front lines that it was necessary to send in tanks and half-tracks to cover their withdrawal. One driver came back horribly wounded in the ambulance he had taken to the front.

"Back to the beach they were brought, to funnel through the evacuation aid station, receive fresh treatment, and be sent back to sea."

POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of October, 1919)

Scientific articles in this number covered "Public Health Work by the Indiana State Medical Association"—this was the Presidential Address of Dr. William H. Stemm, North Vernon; "Diseases of the Prostate Gland and Neighboring Structures," a paper by Victor Lespinasse, of Chicago, guest speaker at the state meeting, and "An Interesting Case of Tuberculosis," by Gardner C. Johnson, of Evansville.

* * *

Editor Bulson discussed "Diagnosis and Cure of Syphilis," "Investments for Doctors," "Prohibition Sequelae," "Selling Patents," and other topics.

* * *

The "cost of living," as at present, seems to have been a common topic of conversation twenty-five years ago. One of our congressmen had remarked that it was not so much the "high cost of living" as the "cost of high living." The editor opined that what we needed most was a full day's work for a full day's pay — a little more sticking to the job and not so much leisure.

* * *

Stock promotions seemed on the upward trend, the editor calling attention to stock sale solicitation from physicians by two of our local sanatoriums. (As we recall, one of these promotions hit some of our doctors rather hard, financially, for it did not "pan out.")

* * *

As usual, even at this late time of the year, there were some delinquencies. It seems that a few of our members delay paying their dues until the end of the year, even though they know that by so doing they jeopardize their right to medical defense through the state association.

* * *

The Indiana Tuberculosis Association had launched its new publication, the *Hoosier Health Herald*, with E. Q. Laudeman, executive secretary of the organization, as the editor.

* * *

The National Safety Council, which has become the leading organization of its sort throughout the entire world, had held its eighth annual meeting in Cleveland. One of the reports presented at this session showed that 70,000 persons died each year of the war (World War I) as a result of accident, in America.

* * *

The controversy as to the "wholesale" removal of tonsils continued to be waged, the editor this time defending the removal of these organs in certain instances, although he was very much opposed to tonsil removal just because one had such things.

Self-praise, via the local newspapers, apparently had again reached epidemic form, complaints being commonly made to the editor of THE JOURNAL.

* * *

It was reported that the chiropractors had again organized for the coming session of the Indiana General Assembly, and that strenuous efforts would be made to obtain a separate board for that group. (They still are at it!)

* * *

Proprietary medicine manufacturers reached an all-time high in the matter of newspaper advertising of their nostrums; it is stated that full-page advertising was not at all uncommon.

* * *

Indiana physicians returning from the armed services were: C. C. Campbell, Indianapolis; E. O. Daniels, Marion; C. E. Orders, Indianapolis; E. L. Titus, Indianapolis; E. M. Bennet, Whitestown; and M. B. Catlett, Fort Wayne.

* * *

All prisoners in the Marion County Jail, Indianapolis, were henceforth to be examined for venereal disease.

* * *

B. R. Kirklin, then of Muncie and now head of the Department of Roentgenology, Mayo Clinic, had announced the limiting of his practice to roentgen-ray diagnosis and treatment.

* * *

The City Council of Fort Wayne had appropriated money for the setting up of a venereal disease clinic, with Doctor Maurice R. Lohman as its medical head.

* * *

Doctor Charles H. McCully, Logansport, had been elected as president of the Indiana State Medical Association at the September meeting.

War Bonds will hasten the day when our men
can say,

"I tank I go home."



THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

NOVEMBER, 1944

NUMBER 11

MEDICAL ASPECTS OF PRESSURIZED AIRCRAFT*

MAJOR GENERAL DAVID N. W. GRANT

The Air Surgeon, Army Air Forces

WASHINGTON, D.C.

You are by now quite familiar with the exploits of the *B-29 Superfortress* in long-range, high-altitude bombing missions against Japan. The combat operation of this superbomber, which is half again as large as the great *B-17 Flying Fortress*, is the realization of a global air strategy conceived by General Arnold in 1939. Specifications for the *B-29* were drawn up in that year by the Materiel Command of the Army Air Forces, and it went into production in 1943.

Aviation medicine played a significant role in the development of this superbomber. In fact, flight surgeons and aviation physiologists, teamed with aeronautical engineers, worked out the basic physiological problems of efficient human performance in the stratosphere long before the *Superfortress* was conceived. In addition, the operation of the airplane introduced a number of special medical problems which were tackled and solved by a group of energetic young flight surgeons.

The potentialities of any aircraft which may come from the engineer's drawing board are no greater than the physical and psychological efficiency of the men who fly it. Flight under various conditions may impose a number of burdens which the human organism is not designed to tolerate. These include various degrees of anoxia, extreme cold, aero-otitis media, aero-sinusitis, intestinal gas expansion, aero-embolism, the vascular effects of centrifugal force, airsickness, hunger from irregular eating times, anorexia from nervous tension, or the physical or mental fatigue which any one or any combination of these factors may produce. Consequently, the development of the *B-29*, which flies higher, faster, and longer than any other in its class, required the formulation of better solu-

tions to the old problems of stress which flight imposes upon the human body.

From the medical viewpoint, the *B-29's* greatest distinction from previous bombers is the pressurization of its cabins to produce a relatively constant air pressure inside, irrespective of the great reduction of atmospheric pressure in a flight from sea level to the stratosphere. There is, as it happens, nothing new in the idea of compressing the air in a sealed cabin to maintain the partial pressure of oxygen in the lungs.

More than thirty years ago, when the heavier-than-air flying machine was just getting off the ground, Cruchet and Moulinier observed with considerable clairvoyance: "As a matter of fact, the (oxygen) problem will never be satisfactorily solved until the crew and passengers sitting in an airtight cabin shall breathe at all altitudes an atmosphere practically identical with that at sea level."

Let us review the physiological oxygen principles which give validity to this statement. Air has weight, which at sea level exerts a pressure of 14.7 pounds per square inch of surface. This weight decreases with increasing distance above the earth until at 40,000 feet altitude the air pressure is only 2.7 pounds per square inch. This total atmospheric pressure of 2.7 happens to be slightly less than the partial pressure of oxygen at sea level. As a matter of fact, when the air pressure decreases to below the 10.1 pounds per square inch found at 10,000 feet altitude, the partial pressure of oxygen is no longer sufficient to maintain an adequate arterial saturation of oxygen in a flyer accustomed to living at lower altitudes. Above 10,000 feet the amounts of anoxia to which he would be exposed increase so rapidly that an attempt to breathe free air between 30,000 and 40,000 feet would result in death within a few minutes.

* Presented at the General Meeting of the Indiana State Medical Association on Wednesday, October 4, 1944.

To maintain normal oxygen saturation of the blood at high altitude, the Army Air Forces provide the flyer with a standard diluter demand type of oxygen mask and regulator. The oxygen is supplied from low-pressure oxygen cylinders. Actuated by an aneroid, the demand oxygen regulator reacts to reductions in atmospheric pressure by automatically increasing the percentage of oxygen in the air breathed by the flyer from the 21 per cent found in free air to 100 per cent when he reaches an altitude of 30,000 feet. If his oxygen equipment is functioning efficiently, his arterial oxygen saturation is still normal and will remain adequate up to 38,000 or 40,000 feet.

Above 40,000 feet even 100 per cent oxygen is insufficient for physiological needs, and the accumulative effects of anoxia will develop with prolonged exposure. The only way to raise the flyer's service ceiling beyond this point is to increase the air pressure at higher altitudes.

This may be done with a pressure demand oxygen mask and regulator, which can increase the pressure of oxygen in the lungs throughout the respiratory cycle by 15 to 25 mm. Hg. This will prevent anoxia up to an altitude of 43,000 feet, and may be used for short periods between 45,000 and 50,000. By maintaining a positive pressure which prevents any possible air leakage, the pressure demand mask at altitudes in excess of 35,000 feet will provide, in addition, a margin of safety not obtained in the diluter demand mask. Nevertheless, it has many of the disadvantages inherent in any closed system of breathing. These include the necessity of maintaining a facial fit of the mask, which is virtually sealed, the discomfort attending prolonged periods of wear, the possibility of the mask freezing at the sub-zero temperatures found at high altitudes, the possibility of small amounts of anoxia developing from malfunction, the general fatigue which frequently results from continued use of an oxygen mask, and the restriction of movement by an oxygen hose of fixed length.

The ideal solution to all this is the development of pressure cabin airplanes. Two early attempts at pressurized flight failed because of mechanical defects. In 1920, the Army Air Corps constructed its first sealed cabin airplane by replacing the cockpit of a pursuit ship with an oval steel tank containing a glass port and a removable cover. Pressure was provided by a wind-driven supercharger designed to push air in at a faster rate than it could escape. The first flight was made in 1921. Shortly after take-off it became evident that the cabin exhaust valve was inadequate to handle the large volume of air forced into the cockpit by the supercharger. As a result, the cabin pressure rapidly increased to a value equivalent to 7,000 feet below sea level, while the heat of compression produced a temperature of 150°F. Despite ear pain, heat, and pressure the pilot succeeded in landing.

Fourteen years later, in 1935, a Frenchman, Marcel Cnigo, flew to 32,800 feet in a pressurized

cabin plane. After some thirty minutes of flight his airplane fell and crashed. Investigation indicated a failure of the exhaust system with a sudden increase in pressure sufficient to burst the pilot's ear drums and blow out the cabin window.

Meanwhile, in 1935, the Army Air Corps began its second pressure cabin project, and in this instance Colonel Harry G. Armstrong, first director of the Aero Medical Laboratory at Wright Field, Dayton, Ohio, made an exhaustive study of the physiological requirements of such a cabin before actual construction was attempted. The airplane, the *XC-35*, was completed by the Lockheed Aircraft Corporation in 1937, according to Army Air Corps specifications. The success of the tests may be judged from the fact that the project led to the award of the "Collier Trophy" to the United States Army Air Corps for the first successful pressure cabin airplane to be flown anywhere in the world.

Two years later the Boeing Aircraft Corporation built the *Stratoliner*, the first pressure-cabin airplane to be used in commercial transportation. Meanwhile, in 1939, consideration was given to the pressurization of Boeing's *Flying Fortress*, but this idea gave way to the decision to develop a bigger and better *Superfortress*, incorporating cabin pressurization.

You have seen exterior views of the great *Superfortress*. I have a slide which shows the distribution of pressurization in the interior. You will see that the entire fuselage is not under differential pressure. The forward compartment and the rear compartments are sealed and pressurized. They are connected by a pressurized tunnel passageway over the bomb bay. In addition, the tail gunner's compartment, a lonely cupola under the rudder, is pressurized.

For reasons of military security, I cannot give you a technical discussion of the methods of supercharging these pressurized areas. The announced altitude performance of the *B-29* is "more than 30,000 feet." Up to this approximate altitude it is possible to maintain a pressure which provides adequate oxygenation of the blood without the use of an oxygen mask. Thus, the greatest practical advantage of pressurization today is to free the flyer from dependence on the oxygen mask at altitudes below 30,000 feet. If the airplane were to continue to climb above this altitude, a point would be reached where the interior pressure decreased to the equivalent of 10,000 feet altitude and the aircrew would then be required to put on oxygen masks. In other words, the effect of pressurization would be to jack up the "floor" of the demand oxygen system from 10,000 to 30,000 feet altitude, and therefore raise the theoretical service ceiling for this type of equipment from about 40,000 feet to the vicinity of 60,000. This is, of course, far higher than any operations contemplated at present.

The practical and potential values of cabin pressurization are numerous. In addition to freeing the flyer from the necessity of wearing an oxygen mask at moderately high altitudes, pressure dis-

turbances of the middle ear, the sinuses, and the gastro-intestinal tract are greatly minimized. Moreover, pressurization prevents aero-embolism, or "the bends," which become a problem at altitudes above 30,000 feet. The sealed pressure cabin acts, to a great extent, as a soundproof, and hence noise levels within the cabin are lowered. Finally, the heat resulting from air compression provides

enough to take those stresses, but how about the human body?

At the time of the development of the *XC-35*, Colonel Armstrong and others submitted themselves to tests which showed that the human body could safely withstand decompression of seven pounds per square inch at a rate of altitude ascent equivalent to 160,000 feet per second. After the engineer-

TRIBUTE TO INDIANA PHYSICIANS IN SERVICE*

LARUE D. CARTER, M.D.

INDIANAPOLIS

"It is, indeed, quite an honor again to be asked to pay tribute to those physicians from Indiana who are now in the military services in World War II.

"Three years ago the records showed that there were two hundred fifty physicians from Indiana who were then in the Medical Corps of the Army or Navy. Two years ago the number had reached eight hundred sixty-two. Last year eleven hundred and eight were reported, and at this time the official records show that there are twelve hundred and sixty physicians from this state who are now or have been officers in the military services of World War II. The records also show that there are now twenty-six hundred physicians who are licensed to practice medicine in Indiana, exclusive of the twelve hundred and sixty who are now in the armed forces. This means that approximately one-third of the physicians from Indiana are now serving as officers in either the Army or the Navy. It should be borne in mind that the two-thirds who are not in service are physicians who are not of military age or are disqualified by physical disability. The military records show that twenty-seven medical officers have been discharged on medical survey. As to how many of these were battle casualties we have no definite record. Eight officers have lost their lives—three in battle and five from other causes. We have no record of how many are missing in action; at least three are prisoners of war.

"Such is the record of the contribution of the medical profession of Indiana to World War II. These officers are serving in all parts of the world—in the islands of the Pacific, on all the European fronts, in Asia and in the Near East. Many of these officers have distinguished themselves, not only in military medicine and surgery but for individual meritorious and heroic acts on the field of battle, some of them far beyond the ordinary call of duty.

"In the beginning of any war there is always an exuberance of sentiment—there is much parading, there is loud cheering, and there is much waving of flags and sounding of trumpets. The first casualty returns are critically viewed with awe and horror. It seems impossible that a man could lose his life in battle or that he could even be wounded or made a prisoner-of-war. Soldiers are feted, honored and lionized. But as the war goes on there is a change in the emotional reaction of the people in the home community. They seem to be less enthusiastic. It becomes commonplace to see a young man shoulder his duffle bag and march away to war. The casualty lists are rather hastily scrutinized, and little attention is paid to them except to search for the names of friends or relatives. What has happened to the people? Why should there be such a change in their emotional reaction? Have they become hard-hearted? Have they become inured to the misfortunes of war? I hardly think so. Have they become unsentimental? Perhaps they have. After all, perhaps sentiment is an expendable and unnecessary emotion. But there is another emotion which is not expendable, and which is most necessary in the affairs of man, and that emotion we call 'sincerity.'

"If I had a message or word to pass on to these friends of ours, these physicians from Indiana who are now in the military services, it would be this: 'Even though the parade is not so magnificent; even though the cheering is not so loud; even though the flags are not waving so wildly, yet our hopes, our fears, our anxieties, our prayers for your safety are just as sincere as they were in the beginning.'

* Presented at the annual dinner of the Indiana State Medical Association, on October 4, 1944.

an excellent source of warmth and reduces the hazard of high altitude frostbite.

These gains were not embraced without extensive investigation of new hazards which cabin pressure may present. The one big question on which the tactical operation of the *B-29* as a pressure cabin airplane depended was this: If a cannon shell holed the cabin, would the crew suffer any effects from the release of air pressure? In aviation medicine this action is called explosive decompression, although it refers to pressure changes not exceeding one-half an atmosphere. There was no question but what the engineers had built a fuselage strong

ing requirements for the *B-29* were established, the Aero Medical Laboratory was again called upon to bring the basic knowledge of explosive decompression up to date.

To provide conclusive evidence, the Aero Medical Laboratory carried out an extended study, using human subjects. A single seat, sealed cabin was constructed with a circular opening at one end that could be covered by a stout sheet of paper. This cabin was placed in a low pressure chamber. Reduction of pressure in the chamber created the required differential inside and outside the cabin. Rupture of the paper drumhead produced nearly

instantaneous decompression of the subject seated within the cabin. One hundred fifty tests, supported by roentgenographic studies, were made on human subjects. Among these subjects were fourteen flight surgeons from the Twentieth Bomber Command. It was demonstrated that decompression of 7.5 pounds per square inch at a rate of ascent of 300,000 feet per second could be tolerated with no discernible injury to the body. The major sensation experienced was that of a cough or a sneeze, resulting from the rush of air out of the respiratory tract with the sudden drop in external pressure.

Another possible danger from explosive decompression is acute anoxia. *B-29* aircrew members are instructed to hold their breath if the cabin pressure suddenly falls, and at once to apply their oxygen masks which are kept hanging over the shoulder at all times during pressurized flight.

Other hazards which attend explosive decompression at very high altitude are abdominal distention, ear and sinus disturbances, aero-embolism, and fear. Intestinal gases expand in volume from three to four and a half times in explosive decompressions between 30,000 and 40,000 feet. Varying degrees of cramping might be expected from rapid gut distention of this potential magnitude. It is usually possible, however, to pass this gas, and so far unusual distress from this cause has not been reported. During a large series of explosive decompressions, the majority of which were experimental, no instance of a ruptured ear drum was noted, nor did any individual report ear or sinus disturbances differing in type or degree from those resulting from the slower rates of ascent ordinarily encountered in aircraft. Indeed, it appears that there is increasing efficiency in ventilation of the ear during sudden decreases in pressure. It is well known, of course, that greater difficulties are presented in the converse situation of a rapid increase in atmospheric pressure, as in descents from high to low altitudes.

The incidence and rapidity of onset of aero-embolism ordinarily is considered proportional to the rate of ascent on the basis that less time is allowed for progressive nitrogen desaturation of the body fluids during a rapid climb. Theoretically, therefore, the extreme rate of ascent associated with explosive decompression should increase the risk of aero-embolism. Practically, however, minimal difficulty has been experienced from this cause up to 30,000 feet either experimentally or in the course of accidental decompressions in flight. Experiences above 30,000 feet have been too few to date to draw statistically valid comparisons, but qualitatively no disturbances have occurred of a nature not previously reported. Of the subjects decompressed to altitudes above 40,000 feet in the low-pressure chamber at the Aero Medical Laboratory, 20 per cent suffered bends during the ensuing five minutes at altitude.

Fear is mentioned among the hazards of explosive decompression because psychological reaction to a new and unknown risk can be as disturbing to an

aircrew's morale and confidence in the aircraft as the existence of a structural defect. The flight surgeons of the Twentieth Bomber Command who joined with the physiologists at the Aero Medical Laboratory in explosive decompression tests were able to return to their groups and squadrons and tell the aircrews that, on the basis of this personal experience, they had nothing to fear.

The flight surgeon's statements were supported by several incidents of accidental releases of pressure during flight occurring in the early phases of *B-29* crew training. In one such instance the blister at the side gunner's station blew out at 30,000 feet. The rush of air blew the gunner out of the blister. Fortunately, wearing his parachute at the time, the startled flyer pulled his ripcord and floated to earth in the manner described in official reports as "without further incident." The *B-29* meanwhile continued on its flight. The crew, of course, had been indoctrinated in the use of oxygen equipment by our Altitude Training Program. The pilot and tail gunner, following instructions, were wearing their masks as a precautionary measure. The other members of the crew had theirs ready, and when they heard the automatic warning horn denoting loss of pressure, they simply put them on. No one suffered any ill effects.

Just as the oxygen mask safeguards the flyer in the event that pressurization fails, so an alternate method of body heating is provided should a failure occur in the heating system. Each *B-29* crew member is issued a new type of electrically-heated suit. The individual can wear this clothing, which includes a two-piece suit, boots, and gloves as an ordinary garment while in the air, and simply plug it in and adjust the heat control when he feels cold. In addition, a type of flying suit known as the "intermediate alpaca" is provided each man for emergency wear.

The care of the wounded in flight has presented a special problem in the *B-29* because of its exceedingly long range. A flyer may become a combat casualty when he is six or eight hours' flying time from his base. Consequently, the flight surgeons have emphasized instruction of each crew member in advanced first aid measures, and two individuals in each crew have received the same course of training given enlisted technicians in the Medical Corps. Control of hemorrhage, the administration of morphine, and the application of splints and dressings are taught each flyer by a series of practical applications. The two men trained as surgical technicians are also instructed in the treatment of shock by administration of blood plasma, units of which are included in the number of medical kits aboard the *B-29*. The problem of training non-medical personnel in technical procedures appeared formidable at first, but, by resorting to every training aid including burlesques, the flight surgeons of the Twentieth Bomber Command have been able to obtain gratifying standards of proficiency.

Two bunks are available in the plane for wounded crew members. In addition, a rigging of web straps

has been devised for carrying wounded on litters in the bomb bay of the *Superfortress*. One airplane can evacuate sixteen patients in this manner.

It was evident to flight surgeons of the original *B-29* organization that flyer efficiency could not be maintained on missions of twelve hours and more without some provision for palatable and nourishing meals aloft.

The Navy, in its long-range flying boats, had solved the problem by installing small but complete galleys. Space and weight considerations militated against this sort of installation on a bomber of the Army Air Forces, and furthermore it did not seem advisable to recruit a reluctant gunner for the additional duty of chef.

Investigation of commercial airline procedure showed that its gastronomic success depended on a pick-up of freshly-prepared hot food and beverages delivered to designated points on the route in accordance with a rather rigid time schedule. Since the meals were prepared to be eaten within a short time, such a system did not fit operations over water and over enemy territory.

The box lunch was an alternative, but not a happy one. It is a poor substitute for a regular meal, and, furthermore, by the time the crew could eat the coffee might be lukewarm and the sandwiches dry or even frozen. Many such lunches are returned uneaten or are thrown out of the nearest hatch.

The solution in the *B-29* was the adoption of a six-place food warmer operated on the airplane's electrical system. Each food warmer contains six individual food trays and twelve one-pint cups, as well as a drawer for holding silverware, fruit, and breadstuffs. The food and drink are prepared prior to flight and packed in the containers, hot or cold. The contents then remain unheated until the food

warmer is plugged in on the electrical circuit. The individual trays make it possible for a crew member to eat when he is hungry and can be spared from his station. Each tray holds enough for a full meal and a snack, and each flyer has two pints of one or two beverages. Various problems had to be worked out, such as the devising of suitable menus and recipes based on standard overseas rations, development of a standard technic for preparation and packing of meals, determination of the safety of the food containers from the standpoint of contamination, and the training of cooks for a flight mess. Favorable reception from the aircrews was the proof of the pudding. The food warmer since has been authorized for use in other types of bombers.

Your wartime interest in the *B-29* is in knowing how much it will contribute to winning the war. The results of the Army Air Forces over Germany are convincing evidence of the value of strategic bombing in destroying industrial means of production and the materiel produced. The *B-29's* are now delivering their bombs to Japanese industries with some regularity, and since production of these superbombers is being emphasized, you may expect a rising tempo in the aerial offensive against Japan, such as you have observed in the past year against Germany. The impact of these great bombers will be felt long after they have done their job in this war, however. They are making war not only global but stratospherical, and the engineering achievement which they represent can do the same thing for transportation in peacetime. Your patients of tomorrow will be riding in the *B-29's* commercial counterpart in comfort and safety, without ear or sinus pain because the pressure will be held constant, and without airsickness because there are neither bumps nor bad weather in the stratosphere.

ABSTRACTS

MULTIPLE BOILS CURED BY PENICILLIN

The rapid disappearance and cure of multiple furunculosis observed in six children under penicillin treatment indicates a result far superior to any previously known therapy for this condition. Rose Coleman, M.D., and Wallace Sako, M.D., New Orleans, report in *The Journal of the American Medical Association* for October 14. It was particularly noteworthy that some of the cases treated by Coleman and Sako had the boils superimposed on prickly heat, a condition which constitutes a common problem in the South, and which often proves to be very refractory to treatment.

PENICILLIN FOR SYPHILIS IN PREGNANCY

Preliminary observations indicate that penicillin has a definitely good effect both on the mother and on the child in syphilis in pregnancy, and on infants who were born with the disease. J. W. Lentz, M.D.; Norman R.

Ingraham, Jr., M.D.; Herman Beerman, M.D., and John H. Stokes, M.D., Philadelphia, report in *The Journal of the American Medical Association* for October 14.

They point out that the treatment of the pregnant syphilitic women, and of the infants who acquired the disease prior to birth, with weekly injections of neoarsphenamine and mapharsen supplemented by a bismuth preparation, "although eminently satisfactory from the standpoint of both preventive and curative medicine, still has several aspects in which improvement may be expected. . . ."

The authors believe it encouraging that among the women treated by them not a single stillbirth or neonatal death has occurred, whereas untreated pregnant women with early syphilis almost uniformly give birth to dead or diseased children. They emphasize, however, that the period of observation of the cases has not been long enough to be certain of the permanent effects of the treatment. The four physicians also report encouraging results in their treatment of congenital syphilis.

PRIMARY ATYPICAL PNEUMONIA*

RUSSELL W. BERNHARD, M.D.†

DONALD W. CHAPMAN, M.D.

IOWA CITY, IOWA

At the present time pneumonia ranks as the third most common cause of death, and in the past few years a new type of pneumonia—so-called “atypical pneumonia,” “virus pneumonia,” “interstitial pneumonitis,” or what many authorities prefer to designate as “primary atypical pneumonia,” cause undetermined, has attracted attention. It has become important because of its relatively benign course and few physical findings, in contrast to the stormy course of lobar pneumonia which formerly frequently terminated in death.

It is a well-known fact that the etiology of atypical pneumonia has not been completely worked out. Most attempts to isolate a filterable virus in the blood, secretions, or the lungs have failed. Many workers have isolated viruses that quite closely resemble so-called “atypical pneumonia virus.” These viruses are known to be the causative factors of lymphogranuloma venereum, psittacosis, and lymphocytic choriomeningitis. Even many of the patients with virus pneumonia have given positive Frei tests. This work suggests at least the possibility that the virus arose from a parent strain. This strain probably resides in animals or birds, and subsequently becomes diversified by passage and adaptive residence in different hosts and tissues. Other infections characterized by atypical pneumonia which clinically closely resembles virus pneumonia are Q. fever, coccidiosis, and toxoplasmosis, but the agents which cause them are not viruses and seem unlikely to have any relation to the widespread infection called virus pneumonia.^{1,2}

Although there have been few deaths, autopsies were obtained on two patients at the Jefferson Medical Hospital, nine at the Minneapolis Children's Hospital,³ and a few other reports appear in the literature. The inflammatory reaction in the lungs, histologically, is chiefly of mononuclear cells without bacteria; cytoplasmic inclusion bodies are limited to the epithelial cells. However, a similar reaction is evoked by *Haemophilus pertussis*, *Pasteurella tularensis*, and toxoplasma toxins and irritative chemicals.

Clinically, atypical pneumonia appears in two forms. In a small proportion of the cases virus

pneumonia may occur concomitantly in epidemics of mild disease of the upper respiratory tract.⁴ However, many are isolated, sporadic, nonseasonal cases of mild to severe degree, occurring chiefly in patients under thirty years of age. The clinical course consists of an insidious, febrile onset, with a progressively regular rise and fall of temperature, without diurnal regularity, reaching at times 103° to 105° F. after the first day or two. The fever is accompanied by progressive malaise, weakness, often severe headache, profuse diaphoresis, and occasional severe chest pain. The latter, however, is rare, because the disease tends to limit itself more to the hilar regions of the lung, and the pleura does not become involved. There is a relative bradycardia. On the third and fourth days cough, usually unproductive, develops. Commonly there are no significant or localized physical findings up to this time, and frequently not for some days. The slowly developing, crescendo-type of course lasts ten to twelve days. Decrudescence by lysis usually occurs, but in a few cases there is a migration of signs and a recrudescence of severity. Occasionally the disease is accompanied by meningeal symptoms, constipation, or abdominal distention. Early in the course of the disease the leukocyte count is relatively low, 10,000 or less in about 60 per cent, and 14,000 or less in 80 per cent of the cases. However, characteristically, in the later stages of the disease the white count rises to 14,000 or 16,000.

Physical findings are conspicuous by their absence. In many cases for the first four to five days no chest abnormalities whatsoever are present. In about 70 per cent of the cases, after the first three days of the disease, fine or medium moist rales make their appearance over the involved areas. It has been our experience that quite often these rales shift from one location to another in one lung, and also to the opposite side, without any definite x-ray evidence of new involvement. The respiratory rate usually runs between 20 and 30 per minute. In only about 10 per cent of the cases is impaired resonance found, and in a similar number bronchovesicular breath sounds are heard. A few authors report splenomegaly in some of their cases.

The complications of the disease are relatively few. There are only two reported cases of empyema in the literature, and no cases of bronchiectasis, unresolved pneumonia, or lung abscess. Major W. K. Cooper showed us a case which radiologically appeared to be atypical pneumonia. Progress films

* Presented before the Delaware-Blackford County Medical Society on July 27, 1943.

† From the State University of Iowa, College of Medicine, Iowa City, Iowa.

¹ Reimann, H. A.: Havens, W. P., and Price, A. H.: *Archives Internal Medicine*, **70**:513-522, 1940.

² Reimann, H. A.: *Journal of American Medical Association*, **111**:2377-2384, 1938.

³ Adams, J. M.: *Journal of American Medical Association*, **116**:925-933, 1941.

⁴ Goodpasture, E. W.; Auerbach, S. H.; Swanson, H. S., and Cotter, E. F.: *American Medical Journal of Diseases of Childhood*, **57**:997-1011, 1939.

showed abscess cavity formation. Two cases of meningomyelitis have been reported.^{5, 6} One of these cases⁶ ended fatally, and an encephalitis was also demonstrated at postmortem. The average hospital stay in many cases was prolonged by weakness, the persistence of cough, rales, and also a relatively slow resolution of the pneumonic processes. In a few cases maxillary sinusitis, otitis media, and peritonsillar abscesses occurred, but these were thought to be secondary to the upper respiratory tract infection.

As in so many diseases, bed rest alone seems to be the best mode of treatment. This, along with symptomatic treatment, with emphasis on adequate nursing care, frequent use of fluids, relatively high carbohydrate intake, codeine for the cough, and oxygen for the more severe cases in which cyanosis and dyspnea occur, constitutes the treatment. In 1939, Reimann used sulfanilamide but felt that it was of no benefit. A few writers have felt that in the type of case in which there is recrudescence after ten to twelve days it may be worth while to employ the sulfonamides to reduce the secondary invaders. Some writers believe that it is probably better to try sulfadiazine for thirty-six to forty-eight hours if blood counts and x-rays are not available, and if there is no apparent benefit, then stop them. In very ill patients a transfusion of either whole blood or plasma from a convalescent donor may reverse the trend of the disease and shorten the convalescent course. The neutralizing effect of the convalescent serum was demonstrated by Weir and Horsfall in their experiments with the mongooes.⁷

Atypical pneumonia is differentiated from lobar pneumonia, in part at least, as follows:

1. An intermittent fever occurs with atypical pneumonia, rather than a continuous fever.
2. Mild leukocytosis and a small rise in the polymorphonuclear neutrophil count are more characteristic of atypical pneumonia.
3. Profuse diaphoresis is more common in virus pneumonias.
4. The respiratory rate is not as high in atypical pneumonia as in lobar pneumonia.
5. There is much less sputum and no prune-juce sputum in atypical pneumonia.
6. Usually there is less prostration with virus pneumonia.
7. One cannot recover pneumococci from the sputum in virus pneumonia.
8. Finally, the x-ray appearance, with its hilar or central distribution, is suggestive of virus

pneumonia. This is a most helpful adjunct to diagnosis.

While the manifestation of virus pneumonia in the chest film aids greatly in establishing the diagnosis, the roentgenographic picture is sufficiently variable to stimulate interest in the subject. Nevertheless, its place in the diagnosis of this disease is more important than in the classical pneumococcal lobar pneumonia. This type of pneumonia must be distinguished from other disease processes occurring in the chest, and probably the most difficult differential diagnosis, roentgenographically, is from ordinary bronchopneumonia. Although the history, physical findings, and age of the patient may be helpful, the roentgen aspect may be almost indistinguishable. From a roentgenographic point of view the disease is so atypical that it does not simulate ordinary bronchopneumonia at all. Here the differential diagnosis from other disease processes become apparent.

Sante speaks of bronchopneumonia as being a pneumonic process characterized by multiple small areas of infiltrate clustering about the bronchi, the result of direct extension. They are soft in appearance, show feathery edges, and never appear discrete or clear-cut. They tend to coalesce, to form irregular areas of consolidation, and there is pronounced increase in the bronchial markings.⁸

Major Bowen, working at Tripler General Hospital in Honolulu, saw a great deal of virus pneumonia during the last decade. He states, "Virus pneumonia only involves portions of the lobe, usually basal, although it has been seen in the upper lobes and involving more than one lobe without increase in symptoms. The infiltrate extends outward from the hilus well into the parenchyma, occasionally reaching the periphery. The roentgen appearance is that of a confluent, mottled fan or rounded area, usually of homogeneous moderate density in the central portion with borders fading into normal lung. It has the appearance of an exudative alveolar infiltrate and is usually more localized and of more even density than bronchopneumonia of childhood or that which complicates adult disease. The usual picture of bronchopneumonia is scattered mottling not confined to one lobe or sharply localized."⁹

From our very brief experience, it is our belief that this description is quite adequate although it obviously, like any definitive discussion, is not all-inclusive. A few cases are presented which might serve to illustrate this disease process as we see it in its different stages and manifestations. There is one type of case that we see more commonly, and this might be regarded as the more typical type of virus pneumonia. Other cases present quite a different picture, which probably can be explained in part by the stage of the disease when the first chest

⁵ Sheppe, W. M.; Osterman, A. L.; Ahroon, C. R., and Zufflucht, J. J.: *Journal of American Medical Association*, **112**:1245-1246, 1943.

⁶ Campbell, T. A.; Strong, P. S.; Grier, G. S., and Lutz, R. J.: *Journal of American Medical Association*, **122**:723-729, 1943.

⁷ Weir, J. M., and Horsfall, F. L., Jr.: *Journal of Experimental Medicine*, **72**:595-610, 1940.

⁸ Sante, L. F.: *The Chest, Annals of Roentgenology*, **11**:235, 1930.

⁹ Bowen, A.: *Acute Influenza Pneumonitis*, *Am. J. Roentgenology and Radium Therapy*, **34**:168-174, 1935.

film is made, but, in my opinion, not entirely on this. These more usual cases, if one clings to one terminology, then become atypical virus pneumonias.

It is not our purpose in this short discussion to correlate closely the film findings with the clinical course of the disease. However, we believe these cases do tend to illustrate the progress of the pneumonic process in the typical and the more atypical cases of virus pneumonia. It should be kept in mind that no x-ray evidence may be discernible in the chest film during the first thirty-six to forty-eight hours of the disease.

CASE I

History: G. S., a nineteen-year-old female student, was in good health until the day before admission, when she developed fever, aching, malaise and an occipital headache. At the same time she started to cough and noted some soreness beneath the sternum. The cough was non-productive. The night before admission she was aware of chilly sensations but had no shaking chill. On the day of admission all of the same symptoms were present in an aggravated form, and when she was examined at Student Health her temperature was 101.

Physical Examination: The patient appeared feverish and acutely ill. Except for a few crackling rales at the right lung base, the chest was essentially clear to percussion and auscultation.

Laboratory: Skin test for brucellosis was negative. Agglutinations for typhoid and paratyphoid were negative. Pneumococci could not be typed by any method. Throat cultures were negative for *B. Hemolytic streptococci*.

Discussion: A chest film taken at the time of the patient's admission to the hospital (Fig. A) showed rather prominent peribronchial markings in the right base, extending inferiorly from a very prominent right hilum. However, we did not believe that a roentgenographic diagnosis of a specific disease could be made from this single examination. A progress film taken three days later (Fig. B) revealed infiltrate in the right cardiophrenic angle, which tended to confirm the presumptive clinical

diagnosis of virus pneumonia. At this point her fever ranged from 98.6 to 103, and she was bothered with a right otitis media. Sulfathiazole was started and was discontinued after two days in which time the ear trouble subsided.

Her temperature continued to spike daily to 103-103.6, and two days later, since the patient appeared quite toxic, another chest film was made. This film (Fig. C) showed marked increase in the infiltrate at the right base and some early infiltration of the left base. Fine crackling rales could be heard at both bases.

A film taken three days later (Fig. D) showed a rather diffuse process involving both bases. At this time her temperature was spiking to 104-105 daily, and fine crackling rales were present at both bases as well as dullness and decreased breath sounds just to the right of the vertebral column, posteriorly.

Two days later, ten days after her admission to the hospital, she was started on roentgen therapy, in desperation, because she was extremely toxic and somewhat dyspneic, requiring oxygen therapy. She was given 100 r. through a 20x20 port to the anterior chest, using 200 K. V. and Thoraeus filtration (H. V. L. equal to 1.95 mm. cu.). The next day she was quite lucid and much improved clinically although her temperature spiked to 103 and a chest film showed no essential change from the previous examination. She was given another 100 r. to the chest, using the same factors as described previously. This was repeated the following day because the patient continued to manifest clinical improvement. By the next day she was much, much better clinically and her temperature was leveling off, so we discontinued the roentgen therapy.

This is the first and only case of virus pneumonia we have treated with x-ray therapy. While we make no claim for this type of treatment at this time, it is interesting that this patient got such a quick response after being one of our sickest patients to date. Oppenheimer recently reported a group of patients with virus pneumonia which he

CASE I

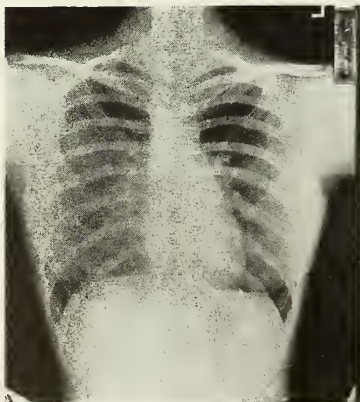


Figure A—Admission.

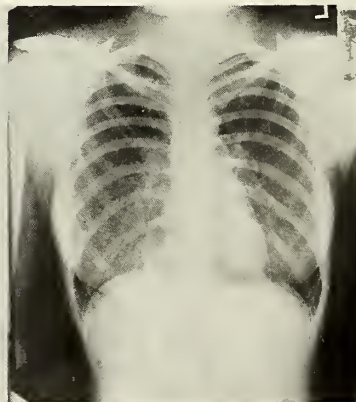


Figure B—Three days later.

CASE I

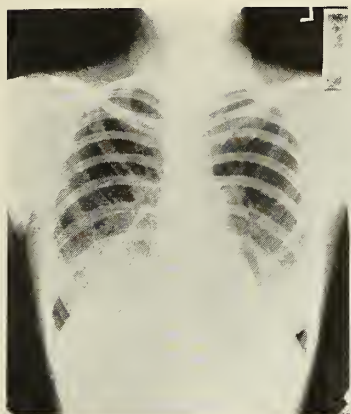


Figure C—Two days later.

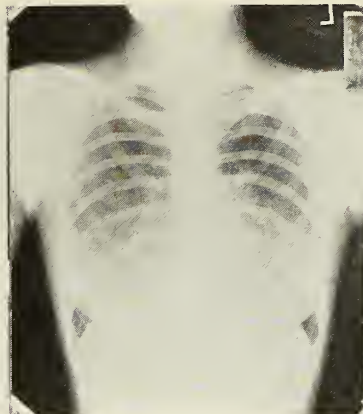


Figure D—Three days later.

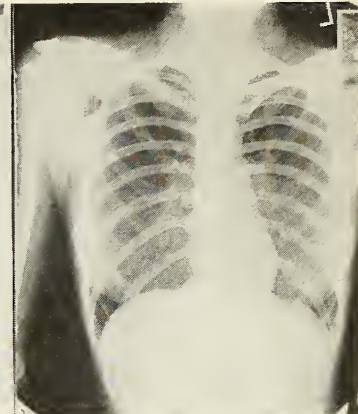


Figure E—Twelve days later.

treated with roentgen therapy, with very gratifying results in the majority of them.¹⁰

The last chest film (Fig. E) made twelve days later, showed essentially complete clearing. At this time there were no chest findings and her temperature had not been over 100 for seven days. She was discharged six days later, clinically well, after her temperature had been normal for four days.

CASE II

History: J. H., a nineteen-year-old male student, who was in good health until the day before admission, when he developed malaise and felt faint. He this time there were no chest findings and her temperature was 102. The next day he had two chills and vomited once. His temperature rose to 103, and he was admitted to the hospital. There was no cough.

Physical Examination: There were moist rales in the right lung base and some bronchovesicular breathing in this area. There was no dullness. Temperature was 104 and R. was 24 on admission.

¹⁰ Oppenheimer, A.: *Am. J. Roentgenology and Radium Therapy*, 49:635-638, 1943.

Laboratory: Two blood cultures were negative. No sputum was available for examination.

Discussion: Fig. A—A chest film taken on admission to the hospital revealed a rounded area of infiltration having a homogeneous moderate density at the right lung base. On his third hospital day his fever rose to 106.6 although his chest film (Fig. B) revealed essentially the same findings as those seen on the admission examination. Sulfadiazine was given with no effect. The last film taken four days later showed considerable resolution of the process although there was significant infiltrate still present. After this last examination he convalesced rapidly and was discharged clinically well. Unfortunately, no more chest films were ordered. It is the opinion of many clinicians that patients should not be discharged until a progress chest examination shows complete clearing with return to normal, roentgenographically.

CASE III

History: J. R., a seventeen-year-old student, was well until six days before admission when he developed malaise and generalized aching. His tem-

CASE II

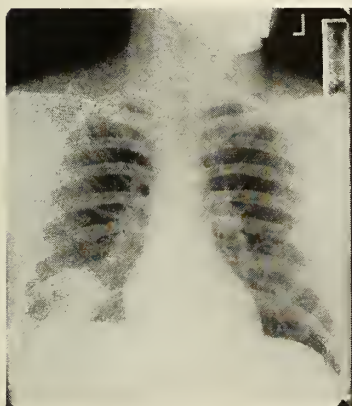


Figure A—Admission.

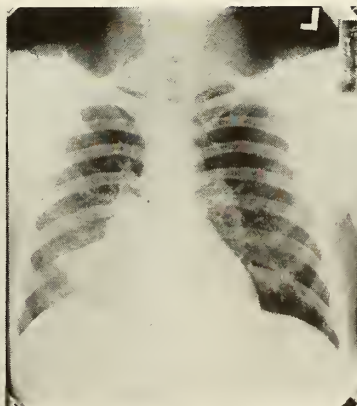


Figure B—Two days later.

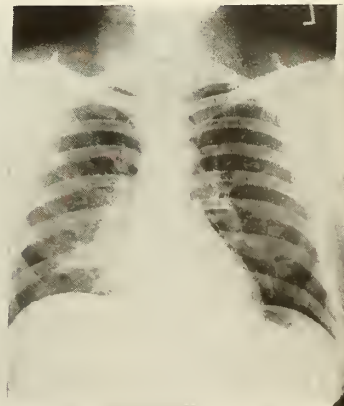


Figure C—Four days later.

CASE III

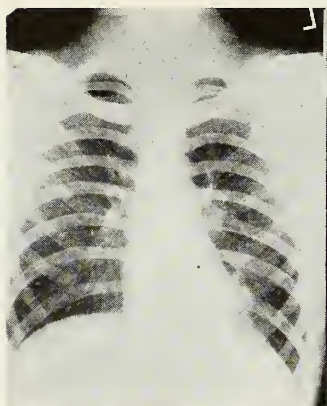


Figure A—Admission.

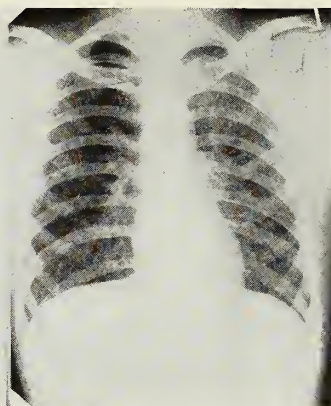


Figure B—Seven days later.

perature that evening was 104.8. He remained in bed for the next three days, feeling about the same except for some headache. He had no chest pain, chills, sweats, cough or joint trouble. Three days before admission he developed a cough productive of a small amount of mucoid sputum. During the afternoon he had three or four chills and his fever went up to between 104 and 106. Because of nausea and vomiting at this time, sulfathiazole was stopped and the nausea and vomiting abated. There was no hemoptysis or chest pain at any time. His cough became worse and the other symptoms persisted, so he was brought for hospitalization.

Physical Examination: The patient appeared subacutely ill, but cooperated well. There was dullness at the left lung base posteriorly below the eighth rib. Vocal fremitus was decreased in this area, and a few fine moist rales were heard.

Laboratory: WBC was 6500. Wassermann was negative. Agglutinations for Malta fever and typhoid fever were negative.

Discussion: A film taken on admission (Fig. A) showed definite infiltration at the left base in the cardiophrenic angle. The patient was treated entirely with supportive measures and progressed

favorably and uneventfully although his temperature daily spiked to 101-103 for about eight days. A progress film taken seven days later (Fig. B) revealed marked clearing at the left base, but some new infiltration in the left apex, particularly in the first intercostal space anteriorly. This infiltration is so typical of that seen in the reinfection type of adult tuberculosis that we think it is wise to call attention to it.

The patient left the hospital five days later after having a normal temperature and being clinically well for three days. Unfortunately, no additional chest films were obtained.

At the university hospital the usual form is the mild case with a relatively short clinical course and roentgenographic findings which clear rapidly, as illustrated by the second case. With a little experience this type of case is easy to diagnose roentgenographically. It is wise to keep in mind the changes illustrated by the other cases for the diagnosis may not be so obvious, depending on when the first roentgenogram is taken. Our only patient treated with roentgen therapy is recorded because it is possible that the good response in this extremely ill patient is something more than just coincidental.

ABSTRACT

NEW DRUG AIDS TREATMENT OF MENINGITIS

The combined use of sulfonamides and penicillin in the treatment of pneumococcal meningitis appears to be more effective than any previous method used in combating this disease, Antonio J. Waring, Jr. M.D., and Margaret H. D. Smith, M.D., Baltimore, report in *The Journal of the American Medical Association* for October 14.

Of twelve patients with the disease who were given combined penicillin and sulfonamide therapy, eleven recovered and one died. "These results," they say, "are better than our experience with sulfonamide alone, with sulfonamide and serum combined, or with penicillin

alone." They point out that prior to the development of the sulfonamides, pneumococcal meningitis was almost invariably a fatal disease. With the advent of the sulfonamides and later its combined use with serum, the mortality rate has been lowered to some extent.

They point out that the mortality rate of the disease is particularly high in infants. "Eight of our twelve cases," they say, "fall under two years of age. With serum and sulfonamide therapy we could have expected to lose six or seven of these eight infants. Under penicillin and sulfonamide therapy we lost one. All four older patients recovered. Under the old form of therapy we would have expected to lose one. . . ."

PRINCIPLES IN THE DIAGNOSIS AND TREATMENT OF PERIPHERAL VASCULAR DISEASE*

LOUIS N. KATZ, M.D.†

CHICAGO

At the outset I wish to make clear that this discussion will be confined to a presentation of some of the underlying principles involved in the diagnosis and treatment of peripheral vascular disease. This is being done for several reasons. First, the field is new and consequently has not outgrown its "growing pains"; not even the nomenclature has been finally settled, although a step in this direction has been made by the Fellows of the Peripheral Vascular Section of the American Heart Association. Uniformity has not been attained in the various diagnostic procedures employed, nor have the values of the various procedures been completely agreed upon. It is my impression that in the field of therapy each expert has his own pet methods and largely discounts those of his colleagues. This is apparent on perusing the published reports and monographs. I shall try as far as I can to present a judicious evaluation of the merits of the various diagnostic procedures and plans of therapy.

Before these matters can be discussed, we should be clear as to what constitutes peripheral vascular disease. In the strict sense it is concerned with the diseases of the blood vessels of the skin and extremities. While general disorders like shock, peripheral vascular collapse, hypertension and the like have been included, they will not be considered here. For the sake of simplicity we can subdivide the diseases into (a) those of arteries and smaller vessels, and (b) those of the veins.

As regards the former, these may be further subdivided into (1) occlusive diseases, (2) vasospastic diseases, (3) vasodilating diseases, and (4) a miscellaneous group.

OCCLUSIVE DISEASES

The occlusive diseases consist chiefly of thromboangiitis obliterans; arteriosclerosis obliterans (either senile, presenile or diabetic); embolic or thrombotic occlusion; and acute, subacute, and chronic inflammatory obliterating endarteritis. In addition, we include essential thrombophilia and polycythemia vera with arterial thrombosis, popliteal aneurysm, and traumatic thrombotic occlusion following injury. Also, the more chronic form of occlusion following the use of crutches or occurring in the presence of a cervical rib, an increased transverse spinous process, and the scalenus

anticus muscle syndrome—all of which cause obstruction of the blood supply to the arms.

Thrombo-angiitis obliterans, one of the commonest forms, is an inflammatory disease affecting primarily males of middle age or younger. The disease involves primarily the lower limbs and consists of the association of inflammatory obliteration and thrombosis of the larger arteries, with similar lesions often involving the veins. Vasospasticity is prevalent. Smoking, rye bread, and a racial dominance among Jews have been implicated, but more recent observations have questioned their primary importance. It is strikingly rare among females in spite of the recent fad of smoking. It is a progressive disease, and like other occlusive processes it ultimately leads to gangrene in many instances.

Arteriosclerosis obliterans is also common. It is a manifestation of arteriosclerosis and has a minimum amount of complicating vasospasm. There is no necessary parallelism between the manifestations of arteriosclerosis and of vascular occlusion. Its dominance in diabetics is well recognized.

In embolic occlusion the heart usually supplies the source of the embolus. It presupposes cardiac disease with clot formation in the left auricle, on the mitral and aortic valves, and less often in the left ventricle. It is an acute surgical emergency, especially when it involves the lower extremities. Closely akin to it is thrombotic occlusion. This is usually superimposed upon an arteriosclerotic plaque and occurs especially at the bifurcation of the aorta, or lower. It, too, may be an acute surgical emergency. Before surgery is undertaken, these two forms must be differentiated from the large vessel spasms that occur following severe trauma or extensive thrombophlebitis.

The inflammatory form of endarteritis obliterans occurs following local or systemic infection, but it is relatively infrequent. In the acute and subacute forms, the sulfonamides may be useful. When a crutch is responsible for occlusive disturbances, it may be necessary to resort to some other walking-aid. When a cervical rib or a transverse spinous process is the cause, surgical resection is the method of choice providing the disturbance is great enough. Relief of the scalenus anticus muscle syndrome is obtained by cutting the belly and tendon of this muscle. Another type of occlusive disease which follows severe injuries, associated with pain and osteoporosis, is occasionally observed.

VASOSPASTIC DISEASES

Of the vasospastic diseases the outstanding form is Raynaud's disease, more properly called Raynaud's syndrome. This may be idiopathic, an ex-

* Presented before the St. Joseph County Medical Society, at South Bend, on February 23, 1944.

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pression of vasomotor instability due to a neurogenic source or to an increased irritability of the digital arteries to chemical stimuli. It is found most often in women, especially the high-strung type, is usually bilateral and involves most often the fingers of the hands. It is characterized by typical episodes occurring during emotional crises or during exposure to cold. Classically, there is a triad of successive color changes, beginning with blanching, followed by cyanosis and ending with redness. Immersion in cold water usually will bring on the attack. As the disease progresses trophic disturbances develop and gangrene may ensue. Often scleroderma may be present in the form of a generalized state or involving the fingers only (sclerodactylia). The tight, pigmented, glistening skin with impediment of motion is characteristic. The interrelation of scleroderma to Raynaud's disease is not clear. It is probable that scleroderma may result from this vasospastic disorder, and the process may form a vicious cycle. It is possible also that scleroderma, a proliferation of collagen in the subcutaneous tissues, may be primary and give rise secondarily to the Raynaud's syndrome. Finally, it is possible that the two diseases are coincidental. Emotional upsets should be avoided and protection from cold encouraged.

Besides the idiopathic form of the Raynaud's syndrome there are the secondary varieties which are more benign and less apt to have the full-blown picture of progression and the many episodes of the color cycle. Trauma to the hands, the use of vibratory or pneumatic tools, the constant hammering of stone masons, et cetera, are common causes of vasospastic disease. This then may in some instances be an occupational disorder. Relief may easily be obtained in them by changing the form of occupation. Vasospasm occurs as a manifestation of thrombo-angiitis obliterans, but here it is apt to involve the lower extremities and is less apt to be symmetrical. Vasospasm will occur also following exposure to cold in susceptible people, or following frostbite or immersion and trench foot.

A benign form of vasospastic disease occurs in children and adolescents, or in older people accustomed to the out-of-doors. This is called acrocyanosis and is a condition in which the hands and sometimes the legs are cold, dusky and cyanotic. It is aggravated by cold and a dependent position of the part, and is relieved by warmth and by elevation. It is important to differentiate this condition from the more serious Raynaud's syndrome.

VASODILATING DISORDERS

Amongst the vasodilating disorders there is that known as erythromelalgia. This is a rare primary disease of the smaller blood vessels associated with intense burning pain in the hands or feet, accompanied by redness and warmth. It is more often found in the feet than in the hands. The blood flow through the part is increased, the normal A-V shunts are wide open, and therefore the venous oxygen

approaches that in arterial blood. The pain is a reaction to temperature regardless of how it is brought about. The normal manner is by the more rapid flow of blood, but it can be brought about, even when the blood supply is cut off, by exposure to an environmental temperature above the critical level. This idiopathic disorder must be distinguished from erythralgia, which is a secondary disorder with burning pain and redness which is sometimes seen in polycythemia vera and in occlusive vascular disease, especially thrombo-angiitis obliterans. In the latter conditions, unlike erythromelalgia, the skin is not warm and the blood flow is less than normal. Furthermore, in the secondary varieties cold, not warmth, aggravates the symptoms. There are some persons who develop redness and pain on exposure to cold. Chilblains (pernio) is a form of this sensitivity to cold, leading to raised red areas. Obviously in these conditions the patient should be protected from cold.

MISCELLANEOUS DISORDERS

In the miscellaneous form of vascular disease should be mentioned periarteritis nodosa, A-V aneurysm and glomus tumor.

Glomus tumors are small (two to three mm.), painful, purplish nodules of the hands and feet due to an exaggerated growth of the elements of the normal glomus. This consists of arterioles, A-V shunts and venules. The color is due to the vascularity of the tumor; and the pain to the involvement of enclosed nerve fibers. Excision is the treatment of choice.

A-V aneurysm is a large intercommunication between artery and vein. This may be congenital and then leads to hemihypertrophy of the involved limb, with increased warmth, perspiration and hair growth. The acquired form follows trauma. In both, a large part of the blood by-passes the arteries and veins distal to the communication, the venous pressure is elevated, and the venous flow to the heart is increased, thereby dilating the latter and increasing the minute output. The heart rate is accelerated and the pulse pressure increased. A thrill and a bruit can be made out over the aneurysm. The venous oxygen above the aneurysm is more arterialized than usual. In the acquired form, when the communication is large, heart failure may ensue. This aneurysm may be distinguished from an arterial aneurysm by manually obliterating it. In A-V aneurysm, unlike arterial aneurysm, this usually leads to a bradycardia, a decreased pulse pressure, and a shrinkage of heart size on x-ray examination. The veins below the aneurysm are often dilated and may be mistaken for varicosities. The intercommunication may be demonstrated by x-ray after injection of radiopaque material, thorotrast, into the artery above the aneurysm. When treatment is required because of the deleterious effect on the heart, surgery with resection is indicated. It is usually advisable to wait several months after the lesion has been acquired before undertaking operation, to permit

collaterals to develop. The treatment of the asymmetry of the extremities in the congenital form is a problem for the orthopedic surgeon. The dynamic consequences upon the heart of large A-V aneurysms cannot be stressed too much. This possibility should always be considered when a Corrigan pulse is encountered.

Periarteritis nodosa is a systemic disease of unknown etiology, associated with fever, leukocytosis and often an eosinophilia. The kidney is often involved. Recent work has suggested that it is allergic in origin. When it affects the limbs it causes, as elsewhere, an inflammation of the adventitia of the larger arteries leading to nodules which can be palpated along the course of the arteries. It may lead to purpuric spots and occasionally gives rise to thrombosis with occlusive manifestations. However, the peripheral vascular picture is only a small part of the entire disease.

As to the disorders of the veins, these can be considered as either (1) phlebitis and thrombophlebitis, or (2) varicose veins. I will have more to say on this subject later.

PHYSIOLOGY

With this background of the diseases concerned, it might be well to discuss briefly the physiology of the vasculature of this part of the body.

From the point of view of blood circulation, the skin serves as a subsidiary but important storehouse of the blood for times of need. More important, the skin circulation, particularly that of the hands and feet, serves as the radiator of the body to eliminate the heat liberated as the various organs perform their work. It is the skin blood vessels that are very vital in the maintenance of the normal temperature which characterizes man as a warm-blooded animal. This is accomplished by the special structures, the A-V shunts, found so plentifully in the skin. These are of the order and size of the arterioles and resemble them in structure. They offer direct communications between arterioles and venules which permits by-passing the more sluggish channels of the capillaries. In this way great quantities of blood can be quickly passed through so that heat elimination can be kept at a maximum. By virtue of nerves, with which they are richly supplied, and chemicals in the blood operating upon the smooth muscle of these A-V shunts, the quantity of blood so by-passed can be made to vary considerably according to need. These shunts serve no function in supplying nutriment to or removing waste from the skin but seem specialized for heat elimination.

In the extremities, besides the skin, are found the long bones which form the framework for locomotion. In their marrow much of the manufacture of blood cells goes on. However, the most important element of the limbs, as far as quantity is concerned, is the skeletal muscles which operate the propulsive mechanism that gets us about on our legs and operates the intricate mechanism which we find so handy in accomplishing our sundry task

with our arms and hands. The muscles of the limbs constitute almost one-half the body weight. The muscle blood vessels are subject to nerve action and, more important still, to locally-formed chemicals which permit the adjustment and distribution of blood in accordance with the need of the moment.

Aside from the eyegrounds, the skin forms a handy but misty inspection chamber of the blood vessels. From its color we can determine in a crude way the quantity and quality of blood present beneath it. From its temperature we can obtain some idea of the rate of blood flow. When we look at the skin, the blood color we see is that primarily in the sub-papillary venous plexus, although in part it is also the color of the skin capillaries.

When the blood supply to a limb becomes inadequate, atrophy of the skin, subcutaneous tissues and muscles develops and osteoporosis appears. Ulcers and blebs can occur and may become infected. When the occlusion is more complete, gangrene and death will occur. Since there are nerves in the extremities carrying sensations, malnourishment of these nerves and their endings will lead to disturbances in sensation: coldness, numbness, tingling, burning, itching and persisting or resting pain. We know that whenever the blood supply to active muscles becomes inadequate there is an accumulation of metabolic products, ordinarily removed and oxidized when the blood supply is adequate. These act in a noxious manner and give rise to pain which we call intermittent claudication. The intimate physiology of these sensations, and their causation, is a fascinating chapter in our knowledge, but space prevents elaboration on this subject.

One other aspect of the physiology of the circulation of the extremities needs to be mentioned. Man is an upright creature, so that a great deal of the blood in his veins is considerably below the level of the heart. The pressure in the veins at heart level is about 10 cm. of blood and the foot is somewhere about 100 cm. below the level of the heart. To bring this blood back to the heart, gravity must be overcome. This is accomplished by two factors. One results from the contractions of the muscles in the lower extremities, as well as other muscular activity, notably respiration, which cause intermittent compression of the veins, and therefore tend to cause local displacement of their blood content. The leg-muscles are under tone, that is, they are constantly in miniature tetanic contraction. In addition, there are the intermittent contractions when the legs are moved. Even when standing still there is some body sway—a sort of miniature of the sway seen in *tabes dorsalis* when the eyes are closed or that following the imbibition of alcohol. Purpose is given to this displacement of blood caused by these intermittent compressions by the presence of valves in the veins. The valves cause these intermittent compressions to result in a unidirectional flow of blood towards the heart. Intermittent motion and vein valves therefore are responsible for blood returning to the heart even

when the gravitational factor is large. When the valves become incompetent, this process is handicapped. With a slower flow through the lower extremities, malnourishment will follow; hence, ulceration, indurations and dull pains occur. With incompetent valves the full force of gravity will be permitted to act upon the veins of the leg, and will permit the venous pressure to rise approaching that of the capillaries. Venous obstruction will operate in the same way. Now the balance of forces that keeps fluid in the blood vessels is upset and the increased pressure dominates over the restraining osmotic pull of the blood proteins, consequently fluid escapes into the tissues and edema results. The malnourishment of the capillaries associated with the sluggish flow leads to change in their permeability which aggravates this state.

This brief cataloguing will suffice to show that the future of development in the field of peripheral vascular disease will be along physiological lines, and that the results to be obtained may become as striking as those already achieved by this line of thinking in the field of heart disease.

DIAGNOSIS

We are now ready to discuss the principles of diagnosis. This is a combination of knowledge of the diseases to be encountered, their origin and their natural history, the combination of symptoms and signs which are most prevalent in each of them, the sequelae which may be anticipated, and the knowledge of the judicious use of the more specialized tests now available.

From what has been said earlier, the significance of the various signs and symptoms encountered in peripheral vascular disease should be apparent. However, they have not been found sufficiently informative in evaluating peripheral vascular disease so that more specialized tests have been suggested.

It is customary to palpate the arteries of the extremities. In the upper extremity the radial, brachial, axillary and subclavian arteries should be palpated. In the lower extremity the dorsalis pedis, the posterior tibial, the popliteal and the femoral arteries should be palpated. Absence of pulsation in the more distal of these vessels may be due to their anomalous situations, and often there is uncertainty of one's skill in evaluating the results of palpation. It is for this reason that oscillometry has developed. In essence, the oscillometer consists of a double blood pressure cuff, the upper one serving the purpose of occluding the blood vessels to varying degrees, as indicated on a dial in millimeters of mercury. The adjacent lower cuff is used as a register of the pulsations at varying degrees of occlusion. In some instruments this is connected with a recording device for permanent records, but ordinarily a second dial showing the angular deviation of a needle is sufficient. While such an instrument may be used to record blood pressure, its chief use is to determine the maximum

excursion recordable in the arteries. For this purpose the pressure in the occluding cuff is lowered by steps of 10 to 20 mm. of mercury and the needle excursion noted in units. The maximum excursion obtainable at each level of the extremity is its oscillometric index. This is smaller; the more distal one goes on the limb. In the upper part of the limb it is normally 5 to 15 units, in the wrist 3 to 10, and in the palm and feet about $\frac{1}{2}$ to 2. It is customary to make comparisons at homologous sites on the two extremities. It is more significant to find an absent pulsation by this means than to be too concerned with minor decreases. Errors in technique of application must be eliminated. It must be recalled that with occlusions of a chronic nature, collateral blood supply develops which is not reflected in the oscillometric index. The value of oscillometric methods is to determine roughly the degree of occlusion and, more important, to help determine the site of occlusion before amputation.

As already pointed out, the temperature of the skin is dependent on the rate of blood flow, discounting blood temperature. A simple method of determining the temperature of the skin is for the physician to palpate it with the back or the side of his hand, but this is, of course, a subjective method. More precise methods involve the use of either a skin thermometer in which the mercury bulb is flattened and placed at right angles to the stem of the thermometer, or the use of electrical gadgets, depending upon the principle of thermocouples. A thermocouple is a junction of two dissimilar metals. Several of these junctions are placed upon the skin and connected in series with similar junctions placed in a thermos flask whose temperature can be read with an ordinary thermometer. Any difference of temperature between the thermocouples in the thermos flask and those on the skin will generate electric potential differences which can be recorded by a suitable galvanometer. These electrical meters are usually marked in degrees centigrade. The temperature on the recording galvanometer minus the temperature in the thermos bottle gives the skin temperature. It is obvious when taking skin temperature that the patient should be placed in a room not too cold, not too warm, not too dry, not too humid, and with draughts at a minimum, and kept there, lying on a bed, with the parts to be examined exposed for about twenty minutes. After all, skin temperature will vary greatly, depending on environmental conditions. Draughts, by causing the evaporation of moisture from the skin, will produce a lower temperature. Unless these precautions are taken it is senseless to determine skin temperature. Normally, the temperature of the upper part of the limb is around 30° and in the fingers and toes around 27 and 25° C., respectively. Skin temperatures are obtained in symmetrical points in the two extremities, starting at the toes and fingers and measuring about every four inches up the extremities. These temperatures give a measure of the local rate of

flow and are therefore perhaps more informative than oscillometry.

In contemplating the diagnosis and treatment of any patient with peripheral vascular disease, it is important to distinguish that degree of circulatory impairment which is organic and irreversible from that which is due to reversible vascular tone. For this purpose various procedures have been recommended to reverse what is called vasospasm. General anesthesia may be used, or spinal anesthesia. The more peripheral somatic nerves of the extremities, the posterior tibial or the ulnar and median nerves may be temporarily blocked by injection with 1 per cent procaine. Obviously, general and spinal anesthesia are rather heroic procedures and are not ordinarily justifiable. The nerve injections require specialized skill and should not be done by untrained persons. Because of this, other simpler procedures have been utilized, such as the injection of typhoid vaccine, but this too is rather drastic. Two simple procedures to accomplish the same end can be carried out by the physician. One way is to induce reactive hyperemia by a five-minute occlusion of the extremity to be studied with a blood pressure cuff, the pressure being raised to above the systolic pressure. It is generally appreciated that the ischemia so induced leads to the accumulation of diffusible metabolic products which widely dilate the blood vessels on release of the occlusion. By so doing, hyperemia and redness is produced and the skin temperature is raised. It normally should approach 31.5°C . with the maximum in the neighborhood of 33.5 to 35° . One hazard in severe cases, which I believe is more theoretical than real, is that the occlusion may lead to pain and may favor thrombosis. Another method of reversing vasomotor tone is to warm the other extremities, say the arms when investigating the legs, or the legs when investigating the arms. The extremities are immersed in a bath of 43°C . for an hour. Suitable containers should be used. A similar result may be accomplished by using blankets on the rest of the body except the extremities to be investigated. This must be protracted and can be assisted by the use of electric pads. This distant warmth operates in part in a reflex manner and in part by raising the temperature of the blood going to the thermoregulatory center of the thalamus, and in these ways leads to dilatation of the blood vessels. With any of these procedures the temperature reached after the dilating procedure has been performed is recorded, and the difference between the initial temperature and the new one obtained after dilatation is an index of how much of the occlusion is reversible. The difference between the maximum temperature obtained in the patient observed and the maximum expected in normals gives an index of the irreversible occlusion. These facts color the treatment, since if no reversibility is demonstrated it is absurd to try to denervate the extremity. The greatest field of usefulness of these diagnostic dilating procedures is, of course, in thrombo-angiitis obliterans. Ordinary skin temperature measure-

ments without attempting dilatation may be valuable in determining the efficacy of conservative and surgical therapy, provided one does not quantitate the results too closely. The study of reactive hyperemia following five-minute occlusion may be useful, since in severe occlusive disease the reactive hyperemia may be minimal, delayed, absent and even replaced by pallor.

A simple bedside trick to determine the presence and amount of occlusive disease in the lower limbs is to determine the disappearance of induced pallor. The patient is placed on his back, the leg is raised, and the soles and toes massaged to empty the skin vessels. Exercising the toes will accelerate this. Then the extremity is hung over the edge of the bed and the time for color to reappear is determined. This normally should occur in ten seconds. Longer delays, up to forty-five to sixty seconds, indicate occlusive disease. A similar procedure may be performed while observing the veins which are emptied by elevation and exercise. The time it takes for veins to refill normally is of the same order as for skin color to return, and occlusive disease will delay their filling. Care must be taken to exclude filling from above when varicose veins are present. An even simpler test than these is to compress manually a region of the skin until blanched and to determine the time it takes for color to reappear. One may work out the normal values for this test for oneself. It is obvious in such testing of skin color reappearance that if the general rate of circulation is sluggish because of peripheral vascular collapse or "forward" heart failure, a retardation in the return of color will also occur.

Another test, which is now rarely used, is the injection of isotonic sodium chloride, 0.2 cc., intradermally to form a small wheal. Normally this disappears in about sixty minutes. In occlusive disease it disappears sooner because apparently tissue pressure is lower, and it may be gone as soon as five to ten minutes. When used, a series of such wheals are placed four inches apart up the extremities. This is a painful procedure and has been replaced by the histamine flare test.

Histamine is known to dilate the arterioles, and in this test 0.1 cc. of 1:1000 histamine acid phosphate is injected intradermally in a series up the extremities. Every few minutes up to twenty minutes the site of injection is examined for a mottled red flare evidence of arteriolar dilatation, and felt for a wheal which results from the change in capillary permeability induced by the histamine. The reaction is graded from 0 to 4+. To avoid the painful reaction, at the Michael Reese Hospital we have put 1:2000 histamine in 0.5 per cent procaine for intracutaneous injection without nullifying the value of the test. And to aid still further in the quantitative evaluation, the temperature of the wheal is measured with the thermocouple gadget and the maximum temperature attained is recorded. The histamine flare is useful in determining the

degree of vascular impairment at each level, to locate the site of occlusion before amputation, and to follow the progress of conservative and surgical therapy. It has been found to be extremely valuable in most clinics.

Another method which is just being developed is the determination of circulation time. This can be done either by using calcium gluconate alone or combined with magnesium sulfate; the end point being the development of a sensation of warmth. The time from injection until the sensation is felt in the fingertips or toes compared with that in the tongue may be used as an index. Recently fluorescein, 4 cc. of a 10 per cent solution, which is visible in the conjunctiva under the ultraviolet lamp has been used. For the extremities small wheals of NaCl. are made intradermally, and the time of appearance of the fluorescein in these wheals under ultraviolet light is compared with that in the conjunctiva. Normally, the time should be about equal; in occlusive disease it is delayed. This fluorescein test has great promise but needs more experimentation. It can be used in the same way as the histamine flare.

The extent of skin vein formation in A-V aneurysm and in varicose veins can be judged from infra-red photographs. This is an interesting but not a practical method for ordinary purposes. The same may be said for the elaborate procedure of examining the skin capillaries under the nail bed with a suitable microscope. These are still of more value to the investigator than the physician. The same is true of plethysmography, either the venous occlusion type or that using the photo-electric cell.

So far we have been concerned with the circulation through the skin, and while the conclusion that impairment of skin circulation is typical of impairment of all parts of the limbs may be true, this need not always be so. Several procedures have therefore been developed for the determination of the impairment of muscular blood flow. One method consists of stimulation of the muscles at a constant rate with a galvanic current and determining the time and rate of the development of fatigue. This is not applicable for ordinary purposes. Much more practical and useful is the measurement of the onset of pain on exercise. This is an attempt to quantitate intermittent claudication, but much useful information can be obtained from a careful history. In its simplest form the patient is asked to walk on the flat at a set pace, and the time until pain in the legs occur is determined. The value of therapy upon muscle flow can be measured in this way. In the case of the upper extremities any gymnastic exercise, including pulling on weights, can be quantitated in a similar fashion. It is also possible for the patient to operate the pedals of a bicycle or the pedal of an old-fashioned sewing machine if such can be obtained. These latter tests may be useful in non-ambulatory patients. It may be possible to combine extension and flexion at the ankle with complete obstruction of the arterial supply to the limb, or

in the case of the upper extremities combining such arterial occlusion with a clenching and unclenching of the fist at a given rate. In all cases the time of onset of pain is determined. It is wise for every physician contemplating any of these exercise tests to set up his own normals by observation on a number of normal subjects.

Before turning to the subject of therapy, a few tests that have been developed for varicose veins as an aid to surgery should be mentioned. The first is the Trendelenburg test. This consists of placing the patient in bed, raising the leg to be examined, placing the finger over the saphenous vein in the fossa ovalis near the groin, having the patient then stand up and determining whether or not the veins fill from above. With the superficial veins thus obstructed, any filling from above means that there is incompetence of the communicating and deep leg veins. Consequently the points of ligation and injection of the veins will have to be altered.

A second test is the Perthes' test, in which a tight rubber tube is placed around the upper thigh and the patient then walks about. If the veins collapse during the exercise, it means that the communicating and deep veins are not obstructed or incompetent. The test may be varied by placing the rubber tube lower on the thigh and again below the knee, so as to localize the level of the obstruction and incompetence. These two tests best determine where the varicosities are to be injected and where the veins are to be tied.

I hope that this presentation will clarify some of the tests in use in the diagnosis of peripheral vascular diseases. The use of cold to bring on vasospastic episodes and erythralgia, and the use of heat to determine erythromelalgia have not been mentioned.

TREATMENT

A discussion of the principles of therapy under the headings of (1) general management and care, (2) vasodilators, (3) physiotherapy procedures, and (4) surgery seems pertinent at this time. This discussion will be confined to vasospastic and occlusive disease, with a short discussion of venous disorders.

Patients with interference of the circulation to the extremities should be advised to maintain good general physical health, should be encouraged to be meticulous in cleanliness of their extremities, using warm, *not hot*, baths, should be encouraged to avoid excessive standing, walking or use of the arms when the symptoms demand it, and should dress warmly. Tobacco is contraindicated, but alcohol is to be encouraged; the former is a vasoconstrictor, the latter a vasodilator besides its other well-known properties. There is no need for any restraint as to diet other than to assure an adequate diet with adequate vitamins. Rye bread should be discouraged. Drinking of large amounts of fluid is to be encouraged. When there is the background of a diabetic state, the latter should be controlled, but in the elderly patient a little hyperglycemia or

glycosuria is more to be desired than absolute rigid control. Bruises should be avoided, the nails cut straight to avoid ingrowing, dermatophytosis should be immediately taken care of but treated gently, and corns and calluses should be treated by a chiropodist who is aware of the impaired circulation. The need of proper-fitting shoes and warm, not woolen, stockings, and the avoidance of garters are obvious. All bruises, infections, blebs and the like should be brought to the attention of the physician immediately, and should be cared for by the physician. Dry skin should be treated by oils. Blebs are often a sign of impending gangrene. Sedation with bromides, barbiturates, aspirin, codeine, sometimes morphine, may be necessary. Papaverine is useful in this direction. This will suffice to show the lines of general therapy.

As to vasodilating drugs, the nitrites are too evanescent for ordinary use. The xanthines, in my opinion, are overrated, but in mild cases can be used in combination with the barbiturates for sedation. Particularly valuable in this group is theocalcin.

Mecholyl, an acetylcholine derivative, is valuable by oral administration, 25 to 100 mgm., three or four times a day. It may be combined with prostigmine which paralyzes the enzyme or esterase which accelerates the destruction of acetylcholine. Mecholyl may also be administered by iontophoresis; a 0.2 per cent solution is impregnated in cotton or asbestos, wrapped around the affected limbs, and over it is placed flexible tin electrodes connected with the positive pole of the galvanometric current, the negative pole being applied to the back. The treatment is continued twenty to thirty minutes, several times a week, and later once a week. The current strength should be increased gradually to about 30 milliamperes and slowly decreased. Care should be taken to avoid contact of the electrode with the skin to avoid burns. In iontophoresis the systemic reactions of mecholyl are avoided at the same time that a maximum local effect is obtained.

Papaverine is a very useful dilator drug and can be administered, grains $\frac{1}{2}$, four times a day by mouth, up to grains 3 to $4\frac{1}{2}$, five times a day. In emergencies, as with embolism, it may be given intravenously slowly, grains $\frac{1}{2}$ to $1\frac{1}{2}$. This drug is not only a dilator but has a sedative action. Untoward effects may be constipation and drowsiness when given in large quantities; some patients react unfavorably particularly with smaller doses, by flushing, slight breathlessness and vague discomfort. Care should be taken to ascertain that a marked drop in blood pressure is not present, a rare occurrence. Depropanex, a deproteinized tissue extract, has its advocates; 1 to 4 cc., intramuscularly, two to three times a week is the dosage recommended.

Dry heat in the form of cradles with the temperature at about 36° C. may be useful as a dilator mechanism. However, when gangrene has developed, particularly when it is infected and amputation is contemplated, a more recent development is to use refrigeration instead of heat. Refrigeration

operates to cut down the metabolism of the tissues and therefore the need of blood to the part; it helps to limit the spread of gangrene; it tends to check the spread of infection, and it serves as an anesthetic agent by its effect on the nerves so that amputations have been carried out with this technique without the use of a general anesthetic. The legs are not frozen but the temperature is lowered close to freezing. Care must be taken to see that the leg is kept dry by using ice bags covered with dry towels. A special trough in which to place the leg has been used. Results have been good. Thus, at times heat locally is valuable; at other times cold is preferred. Each case must be carefully evaluated. Diathermy and other drastic procedures for warming the leg are not to be encouraged although an electrically-heated boot may be a good substitute for the cradle.

In the fields of physical therapy the pressure-suction boot has had its vogue but is now being used less and less. The positive pressure used is 20 mm. of mercury for three seconds, and the negative, 80 mm. Hg. for 12 seconds; the treatment is carried out for several hours daily for many weeks. The duration of each treatment and the course is varied according to the condition of the extremity. It is to be avoided when there is thrombophlebitis, which limits its use in thromboangiitis obliterans, in which thrombophlebitis is frequent. It is to be avoided when infection is present. Its greatest value is in recent embolism, in some cases of Raynaud's disease, and in the diabetic form of occlusive disease.

Recently this procedure has been replaced to some extent by the technique of intermittent venous occlusion, where periodically for one minute in every two or three minutes the pressure in the cuff is raised to about 30 to 60 mm. Hg., and this repeated for fifteen to twenty minutes three times a day for days or weeks. Edema should be avoided. A homemade contraption with the patient carrying out this procedure combined with a pulley system to raise the leg between periods of venous occlusion has the merit of keeping the patient occupied during the tedious long stay in bed. The contraindications for this method are the same as for the pressure-suction apparatus. Graded exercises while in bed, consisting of elevating the leg, moving it, and then placing it over the bed, has its advocates and can be ritualized. Oscillating beds, I believe, are an unnecessary luxury.

The use of sitz baths is to be encouraged in some patients as a means of causing dilatation and relieving discomfort. CO_2 baths may serve a similar purpose. Contrast baths are not profitable and should be avoided. The use of concentrated salt or sodium citrate solution in large quantities is not widely practised. The same can be accomplished by urging drinking of large quantities of fluids. Use of typhoid vaccine and Na iodide thiosulfate is not recommended. Physical fever therapy is better than typhoid injections and may be employed cautiously.

Finally, the indications for surgery are: (1) more permanent dilatation, (2) relief of pain, and (3) amputation. Sympathetic denervation, best accomplished in the lower extremities by lumbar ganglionectomy, should be done only in those forms in which reversible occlusion has been demonstrated by the diagnostic tests previously mentioned. The use of ganglionectomy (especially in Raynaud's disease) in the upper extremity has not lived up to expectations, and in no way compares to the value of this same procedure in the lower extremity. The difference between this operation on the upper and lower extremity is that in the latter it is a preganglionectomy and in the upper extremity it is a postganglionectomy. There is sufficient evidence to show that when the final neurone, causing vasoconstriction, is removed, the susceptibility of the denervated blood vessels to circulating adrenaline and other humoral substances in the blood is increased. It is for this reason that lately the operation has been modified so that the fibers going to the ganglia are destroyed and not the ganglia themselves, making the upper extremity operation also a preganglionic denervation. In expert hands the results have been more gratifying. This preganglionectomy also avoids the Horner syndrome. In all these operations the possibility of nerve regeneration is to be considered and is one of the reasons why benefits may sometimes be only temporary. Usually regeneration does not occur for one-half to one and one-half years. The idea behind sympathectomy is that one removes permanently, or for a time, the normal or hyperactive vasoconstrictor nerve elements which give rise to the reversible part of the interference with blood supply.

Sometimes nerve block of the peripheral nerves or of the ganglia may be considered for the relief of intractable pain. In the former, motor paralysis will ensue. One may even consider the operation of cutting the dorsal roots of the appropriate segments of the spinal cord, a rather heroic procedure.

Surgery plays a more important role in the removal of the gangrenous part of the extremity. Unless rapidly-spreading infection sets in, it is wisest to wait for the gangrene to delimit itself, taking due precautions to avoid infection, especially by avoiding moisture on the limb. When amputation is contemplated, it is important to utilize the oscillometer, the histamine flare test, the circulation time test and perhaps radiopaque injections into the artery to determine the site of occlusion. This is the only time, I believe, that one is warranted in injecting thorotrast for visualization, except, of course, for the possible use of thorotrast injection to aid in the diagnosis of acquired A-V aneurysm before surgery is undertaken. Incidentally, ordinary x-ray pictures of the vessels of the limbs with soft tissue technique may reveal calcification of the vessel, but this is no indication of the amount of occlusion, since occlusion may be present without much calcification, and vice versa. When amputation is considered, aside from the selection of the

best site for the later use of an artificial limb, the most important consideration is to be sure that the amputation is done above the site of occlusion, otherwise the troublesome complication of gangrene of the stump will be very upsetting. The surgeon is thus faced with the desire to save as much of the extremity as possible, and yet hesitates to go too low because of the risk of gangrene in the stump with the necessity of further major amputation.

DISEASES OF THE VEINS

Before closing, a few words about diseases of the veins are pertinent. The diagnostic tests for varicose veins and the action of gravity in favoring the production of this condition in the extremities have already been mentioned. Varicose veins arise because of congenital deformity or disease of the valves in the veins; the latter may be traumatic or infectious. They arise also because of the development of phleboscrosis with dilatation of the veins rendering the valves incompetent. Often varicosities are the result of thrombosis or other obstruction higher up. Thus the varicosities following pregnancy are explained. The capacity of varicose veins may be so large in some patients that when the upright position is assumed, so much blood accumulates in the veins that dizziness, faintness, and even collapse may occur because some of the blood ordinarily returning to the heart accumulates in these widened veins. Except for cosmetic purposes varicosities, when mild, should at first be dealt with conservatively, using elastic stockings up to the groin and avoiding constricting garters. Ulcers and indurations are complications which may require the use of elastic bandages; the ulcers may be dressed under the bandage with antiseptics like gentian violet, merthiolate and perhaps the sulfonamides.

When conservative therapy is not quickly effective, when dull aches or persistent ulcers or indurations interfere with the activity of the patient, when edema is persistent or the cosmetic result is disturbing, more radical treatment by surgery is advocated. This consists of high ligation of the superficial veins with ligation of such incompetent communicating veins as have been demonstrated, and injection of the varicose veins below the ligation some ten days later with either concentrated salt-sugar solution or some other sclerosing material, such as 5 per cent K oleate. Care must be taken that there is no obstruction above, causing the varicosities, and that the deep and communicating veins are not obstructed. As mentioned, incompetency of communicating veins can be dealt with, as found, by ligation. Occasionally the sclerosing material may leak out of the vein and cause sloughing and induration. Immediate use of distilled water to dilute the irritant locally is to be encouraged. Thrombosis following operation with ensuing pulmonary embolism is a hazard that occurs, but such embolism may occur in untreated varicosities. I believe that the surgery of varicose veins should be left to the specialist and not done in ordinary office practice. It should not be done

in the elderly, in the cardiac patient, in the presence of tuberculosis or phlebitis, or when the deep veins are obstructed.

The other important condition of the veins is thrombophlebitis. A number of varieties are encountered. It may occur following injection of intravenous material, and it may result from extension from local infection. In such instances the larger veins may have bland, loose thrombi which form the source of pulmonary emboli. Thrombophlebitis may occur as part of the picture of thrombo-angiitis obliterans. It occurs in general infectious diseases, in polycythemia vera, in heart disease with congestive failure, and in varicose veins. One particularly disturbing variety, whose etiology is not too well understood, is thrombophlebitis migrans. Here episodes of thrombophlebitis occur in far distant veins. "Milk leg" is a form of thrombophlebitis which occurs following pregnancy. Pelvic infections and pelvic surgery are often associated with thrombophlebitis, and is one cause of troublesome pulmonary embolism. This may be true also of abdominal operations. It is for this reason that passive and active exercise of the lower extremities and as short a stay in bed as is feasible is encouraged following operation. A rare interesting form of thrombophlebitis is that in the axillary vein following injury.

Acute thrombophlebitis is diagnosed by the occurrence of fever and leukocytosis, with tender, red, elevated streaks in the extremities over the course of veins. This occurs most commonly in the legs. It demands bed rest, elevation, and warm moist packs for ten to eighteen days. The elevation encourages venous drainage and lessens edema. Vasospasms may occur in this condition and aggravate the interference of blood flow to the extremities. The use of procaine nerve block to alleviate this is ordinarily not necessary. Massage and

movement should be avoided to prevent the loosening of emboli. The use of heparin and perhaps dicoumarol is indicated. Experience has shown that the former accelerates the healing of acute thrombophlebitis and in all likelihood the latter should have a similar effect.

Once the acute stage is over, methods to counteract chronic venous insufficiency in the form of elastic stockings or other elastic support may be necessary until a sufficient collateral blood supply develops. In thrombophlebitis migrans the possible benefits to be derived from sulfonamides, or perhaps penicillin, demand more testing.

Venous thrombosis often occurs whenever the circulation is slow, whether by local obstruction or by congestive heart failure. Thrombosis of the veins in the absence of infection is often overlooked clinically. Many times bronchopneumonia is diagnosed when in reality the condition is a pulmonary infarction. This results from an embolus from an unrecognized thrombosis in the superficial or deep veins of the leg, although, of course, thrombi from the heart itself are a common cause of pulmonary embolism.

CONCLUSION

In conclusion, may I state that my purpose in writing this paper was to present a few principles which may serve as quick guides for immediate practical use. If the reader has been provoked to realize that this is a growing and important area of disease of the cardiovascular system, to read with more interest the texts, monographs, and current publications appearing in this field, and, most important, if he has been convinced that here is another field in which the understanding of physiology, normal and abnormal, offers great promise in the rational approach to diagnosis and treatment, then the purposes of this paper have been fulfilled.

ABSTRACT

STUDIES INDICATE THAT THIOURACIL MAY BE OF VALUE FOR TOXIC GOITER

Recent investigations indicate that the drug thiouracil promises to be of great value in cases of thyrotoxicosis, also known as toxic goiter, in which operation is inadvisable or contraindicated, *The Journal of the American Medical Association* declares in an editorial in its September 16 issue. In the same issue, William S. Reveno, M.D., Detroit, reports on results obtained from treating nine patients with thiouracil. Six of them, he said, showed results that appeared as good as those following the successful surgical removal of the thyroid gland.

"Of nine patients treated with thiouracil," Dr. Reveno said, "six showed satisfactory results characterized by cessation of disturbing symptoms, fall in basal metabolic rate and gain in weight. . . ."

"One patient in whom diabetes mellitus coexisted, and who had been taking iodine for six years, failed to respond to therapy.

"Another patient responded favorably at first but developed rapid enlargement of and hemorrhage into the gland and was subjected to surgery.

"The third failure was of a patient who, while showing some clinical improvement, failed to show a drop in basal metabolic rate during the short period she was under observation. . . ."

The Journal, in its editorial, points out that although the operative treatment of toxic goiter is generally successful, the ultimate result is uncertain, inasmuch as the removal of the thyroid interrupts a vicious circle but does not reach the fundamental cause and thus is not a curative procedure.

"Whether or not thiouracil will prove to be a satisfactory substitute for surgical treatment of toxic goiter," *The Journal* advises, "cannot be stated on the basis of present limited experience. The drug promises to be of great value in cases in which operation is inadvisable or contraindicated."

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA

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NOVEMBER, 1944

Editorials

HAIL THE AIR CORPS!

Fifteen hundred eighty-four folk registered at the ninety-fifth annual convention of the Indiana State Medical Association, at Indianapolis, to honor the Army Air Corps. Some twenty-five officials of the Corps, headed by none other than Major General David N. W. Grant, honored us with their presence, many of them occupying places on the scientific program.

The Murat Temple was the mecca of Indiana Medicine for the duration of the convention, and the local committee, headed by Dr. Bert Ellis, did a notable job in the planning and carrying on of the various programs.

The registration was announced to open at eight o'clock, Tuesday morning, and no sooner had the gals seated themselves at their desks when they became busy, the registrations continuing until about the hour for the Wednesday-night banquet.

The Exhibit Hall was a beautiful spot, the decorations being the best we ever have seen at a state convention. This spacious hall gave each exhibitor plenty of room to display his wares and to really talk to Hoosier physicians. Several exhibitors expressed themselves as being elated over their reception.

Weather conditions, except for a rather high temperature the last day, were well high perfect;

just a trace of rain here and there, and a bit of sun every day.

The opening session got under way on time, as did all other parts of the program. The Section meetings were well attended, and it was noted that there was considerable more discussion of papers than in former years. It is evident that physicians are "on their toes" these days.

Both sessions of the House of Delegates were well attended, and the final session, Thursday morning, will go down in the records as a momentous occasion, principally because of the interest in the Health Insurance Program that had been proposed. This discussion lasted for several hours, and finally resulted in the passing of a motion to hold a special session of the House of Delegates, which has been set for November twelfth, at Indianapolis, due notice of which appears elsewhere in this issue of THE JOURNAL.

The Air Corps officials present were profuse in their comments regarding the manner in which Indiana Medicine carries on its business affairs, several of them expressing their amazement at the serious manner in which we attack various problems. General Grant, in particular, had a good time; it is apparent that he likes to come to Indiana, and, of course, we are always glad to have him come.

The election of officers resulted as follows:

President-elect: Jesse E. Ferrell, M.D., Fortville.

Treasurer: A. F. Weyerbacher, M.D., Indianapolis (re-elected).

Delegates to A.M.A.: H. G. Hamer, M.D., Indianapolis, and George R. Dillinger, M.D., French Lick.

Alternates: Karl R. Ruddell, M.D., Indianapolis, and A. S. Giordano, M.D., South Bend.

Dr. E. M. Shanklin, present editor of THE JOURNAL, was re-elected for another year. Two members, Bert Ellis, M.D., of Indianapolis, and Charles N. Combs, M.D., of Terre Haute, were elected to serve on the Editorial Board, replacing James O. Ritchey, M.D., of Indianapolis, and Robert V. Hoffman, M.D., of South Bend.

The Sections on Medicine, Surgery, Ophthalmology and Otolaryngology, and Anesthesia held their meetings on Wednesday afternoon, October fourth. Section officers were elected, as follows:

Section on Medicine: Chairman, William M. Dugan, M.D., Indianapolis; vice-chairman, Wemple Dodds, M.D., Crawfordsville; secretary, Marion R. Shafer, M.D., Indianapolis.

Section on Surgery: Chairman, George Collett, M.D., Crawfordsville; vice-chairman, J. Robert Doty, M.D., Gary; secretary, William N. Wishard, Jr., M.D., Indianapolis.

Section on Ophthalmology and Otolaryngology: Chairman, J. V. Cassady, M.D., South Bend; vice-chairman, Edgar C. Davis, M.D., Muncie; secretary, H. C. Wurster, M.D., Mishawaka.

Section on Anesthesia: Chairman, Russell W. Kretsch, M.D., Hammond; vice-chairman, Harry

Knott, M.D., Plymouth; secretary, John M. Whitehead, M.D., Indianapolis.

French Lick was selected as the site for the 1945 convention.

Thus ended another chapter in Indiana Medicine, with the third largest registration in its history; we hope that next year our members in service will be back to add their chapters!

THE ARMY AIR FORCE AND ARMY BURN EXHIBITS

The two exhibits displayed by the Air Corps deserve special mention, just as they attracted

special consideration on the part of those attending the convention. These were placed at the entrance to the exhibition hall, and were so arranged as to enable the visitors to get a panoramic view.

One exhibit, "Burns from Battlefield through the General Hospital," had to do with burns, as well as other casualties, showing the progress of the patient as he left the field of battle until he reached the general hospital. A casualty is first attended by a Company Aid Man, as he is called. He is usually a "non-com," and knows how to use plasma, if needed. He is also permitted to use morphine in certain cases. He makes a temporary dressing, then sends the patient to a Battalion Aid Station some three hundred to eight hundred yards behind the fighting line. There the patient is attended by a physician, occasionally with a nurse in attendance, if there is one available. The dressings are checked and such changes made as are indicated.

Then the casualty is taken farther back to a Collecting Station, later to the General Hospital. This Collecting Station, also known as a Clearing Station, is located some one thousand to two thousand yards behind the battleline.

In the General Hospital the casualty undergoes another examination and is treated accordingly. If surgery is indicated, this is done there; if after a short time the casualty is completely restored, he is again returned to active duty. Others are sent to some general hospital or returned to this country.

A young chap who was an attendant at this exhibit showed an amazing knowledge of just what was done with casualties. We learned that he was in the African invasion and had himself been a casualty. He gave his name as Private First Class Rolland Sanner, Jr., his home being in Baltimore.

He advised us that men in the American Army had the best medical care of any army in the world — quite enthusiastic about this point.

The second exhibit had to do with the "Army Air Force Convalescent Training Program," this being the official title. There are seven Convalescent Hospitals in the States. The patients come in from four different sources:

1. Point of Debarcation.

2. Air Force Regional Hospital.

3. General Hospitals.

4. Air Force Rehabilitation Center.

Upon arrival at the Convalescent Hospital the casualty is placed under the care of a medical officer, usually a flight surgeon, one with overseas experience. They are classified into four general groups:

1. Those in better physical condition and about ready for discharge from the hospital; 2 and 3, known as the intermediate group; and 4, bed patients.

Each patient has five hours of organized activity each day, and four hours when he is "on his own"; that is, he can choose as to what he will do during this period. (Mental cases are given a complete psychotic examination and disposed of as conditions warrant.)

SPECIAL HOUSE SESSION

The House of Delegates of the Indiana State Medical Association will meet in special session at the Indianapolis Athletic Club, at 9:30 A.M., November 12, 1944. The business to come before the House at this session is a consideration of some plan for prepayment health insurance.

This matter was the chief topic before the Thursday morning session of the House at the recent state convention and, due to the extreme importance of the proposition and the fact that the plan seemed not to be thoroughly understood by the delegates, it was deemed wise to hold a special session.

It was strongly urged that delegates discuss all phases of the proposed program with their local county societies, and it is hoped that this has been done. We regard this as one of the most important, vital matters that ever has come before the House. We feel that this is a *MUST* program, and that some plan should be adopted ere it is too late. So many of our state associations have entered into some such arrangement and so much publicity has been given the various plans that there is a decided *demand* among Indiana folk that *we* do something about it.

Whether we adopt a Service Plan or an Indemnity Plan is, as we view it, beside the question—the important thing is that we *do something*.

Let us, then, approach the problem on November twelfth with an open mind; let us discuss all the phases in a concise, concrete manner—*let's do something about it!*

The patient has a choice of vocational training or can choose an educational course. One man, for example, elected a college course and got his degree while still in the hospital. Another, with some knowledge of radio work, elected that subject, and has since been discharged and operates his own radio repair and sales store in an eastern city.

Upon receiving a hospital discharge the man goes to the Disposition Board, which either discharges him or returns him to the Army. If a man elects to stay in the Army, even though he is not able to perform full military service, some opening is found for him, if possible.

This rehabilitation program is far different from that of World War I; the casualties, where it is at all possible, really *are* rehabilitated; they leave the service equipped to carry on for themselves.

After seeing these two exhibits and having talked with the men in charge, one can no longer wonder why our Army death rate is so low, nor does one fail to understand just what is being done for the casualties who survive their wounds. Verily, GI Joe is being well cared for in this war!

FLORENCE EVA DILLAN

With the sudden passing of Miss Dillan, known to thousands of physicians over the country, the profession of medicine loses an old, stanch friend. For some forty years Miss Dillan attended meetings all over the country as a medical reporter. At one time she was one of three reporters in the whole nation who were deemed competent to report medical meetings of all kinds.

Here in her own home state, of course, she was known to every physician who ever attended a state convention, for through all these years she was "head reporter" at these gatherings.

At the recent Indianapolis session she was on the job, as usual. We were chatting with her one evening, reminiscing on the events that had taken place in Indiana Medicine during four decades. Jokingly, we planned to attend such meetings for at least ten more years, but fate decided otherwise, as she was taken suddenly ill while dining with friends, and died a few hours later.

She had been working diligently on the notes of the Indianapolis meeting, and after her death many of these papers were found on the desk in her office just as she had left them, many of them incomplete.

Thus, do we record the passing of an old friend, a woman who will be sorely missed not only for her unusual ability in her chosen profession but because of her most amiable disposition and the hearty greeting with which she met her thousands of personal acquaintances in medical circles throughout the land.

We of THE JOURNAL staff will be lost without Miss Dillan; for many years she has rendered invaluable assistance in getting out our work. She

was not only a good reporter, but many essayists have her to thank for the corrections she made in their manuscripts; corrections not only as to spelling, punctuation, and the deleting of split infinitives, but corrections as to factual matters. She possessed a keen medical mind; she had no difficulty in attuning herself to the new nomenclature and the newer therapy.

Miss Dillan's place literally cannot be filled; she was of the "old school," and, being just that, had learned to have everything shipshape.

We quote the sentiment expressed by one of her fellow reporters: "She was a beautiful woman; she had the best life of all of us who reported together, because she enjoyed herself as she went along, and she was so sweet and so simple in her tastes. Peace to her soul! I know that she will have her reward."

As for THE JOURNAL staff, we shall accord her a place in our little "Hall of Fame"; she deserved the honor, and we are more than glad to accord it.

THE SIXTH WAR LOAN

The Treasury Department has announced that the Sixth War Loan is up for November and December, and has requested all medical periodicals to broadcast this information. Treasury officials opine that this War Loan will be the "toughest to put over," for many reasons, chief of which is the fact that too many folk are becoming rather complacent about this war business. Our successes in Europe, plus the many victories in the islands of the Pacific, seem to have lulled us into a state of optimism that is none too good for us.

It is pointed out that even though the European war would be over soon, there remains the war against the "Nips." We are advised that *it will cost almost as much to fight Japan, alone, as it did up to now to fight both Germany and Japan*. Greater distances are involved, plus the more costly types of equipment used. The increased freight cost to the Pacific area, over that of the Atlantic, is well over twenty-five per cent, *and it takes twice as many ships to carry the same amount of freight*.

Another item that we cannot overlook is the plain fact that even after the European war has become history, for a considerable period the United States will have to be spending dollars over there.

Again referring to the Japanese angle of the matter, from now on it is definitely an "all out" war — we trust it means a war of extermination.

So it is up to us to continue to loan these necessary dollars, we folk here at home; dollars that will come back to us in due time, probably when we need them most.

We are not at all in accord with the recently-announced ruling that War Bonds may be cashed at any bank, right this minute. That means an

additional drain on the Treasury, for there are far too many folk whose patriotism wanes, once they learn these bonds can be turned into ready cash, but it so happens that we are in no way connected with the Treasury Department!

Let's buckle down to this job, Hoosier Medicine; we are busy, we are making good collections; let's turn some of it — a lot of it — to a better use than we may have planned, and there is no better use to make of current assets than to hand them over to the Greatest Uncle in all the world — Old Uncle Sam. And while we are doing that, let's make it very plain that this money is for bullets and such truck as is used to kill off the hellions responsible for this war.

Buy Bonds to the limit—then buy some more!

NOVEMBER SEVENTH

THE JOURNAL definitely is not in politics; we make no effort to sway medical opinion in matters political; however, we *are* presently concerned with many medical problems that have a political slant. This is true in local, state, and national affairs; we have a definite concern in the selection of those who will make up the Indiana General Assembly; with those who will represent us in the national Congress; and, not the least, with the individual who will sit in the White House for the next four years.

The issues, insofar as we are concerned, are clearly defined. Locally, we have to consider legislation that will be proposed in our own state, legislation that may affect the medical profession of Indiana. We must see to it that those who are opposed to the upholding of our Medical Practice Act do not receive our support, and lend every aid to those whom we know to be our friends.

It is patent that the drugless adherents are prepared to make a strong campaign for a separate board, to which we are unalterably opposed. This fight has gone on for years, and so far we have been successful in preserving, intact, the basic medical law of 1897. And this law must be preserved until such time as a new law is enacted.

It is in Congress, however, that the greatest danger lies; we must not be complacent in the fact that the Wagner-Murray-Dingell Bill has languished on the desk of a committee chairman for many months; outspoken utterance of candidates, here and there, make clear the fact that even though this law is never enacted there will be proposed many others along the same line, some of them more inimical to our interests, perhaps.

We have a pretty good "line" on those who now represent us in Congress, and the new aspirants can readily and easily be checked. This is no time to vote a partisan ticket — we have too much at stake. The physician who votes "straight" Demo-

cratic or Republican, just because he is a member of that party, and who disregards the status of his candidate in matters relating to medicine is a traitor to his profession.

And, when we come to consider the two men who are seeking the highest office in the land, the same things apply — the same yardstick must be used.

During the closing week of September both major candidates seemingly "opened up"; they began talking out loud; and it is our prediction that ere voting day comes around, each of these men will have made their position definitely clear in matters with which we are so vitally concerned.

On November seventh we will have voted for our thirteenth Presidential candidate, and never in all those years, since 1896, have we ever known a time when so many vital issues are to be determined. We must think of post-war conditions, and we must consider the many economic changes that are upon us in the very near future. Of these things we must think, but we, as physicians, owe a duty to our profession — a profession that must endure for all time. VOTE YOUR CONVICTIONS, NOT YOUR PARTY TICKET!

Editorial Notes

It was quite apparent that the September number of THE JOURNAL made a smash hit throughout the nation. The editorial staff was continually showered with compliments during the convention.

We had an off-the-record comment from an Air Force official to the effect that this organization really is short of trained medical men, which no doubt accounts for the many assignment changes that recently have been made.

The Editorial Board held a meeting immediately after the close of the first session of the House of Delegates, Tuesday afternoon, with practically all members present. The two newly-elected members did not show up, probably because they were bashful; we'll take that out of 'em in no time!

Charles N. Combs introduced a resolution — passed by the House — to the effect that a committee be appointed to arrange for our hundredth anniversary, in 1949. While that is some five years ahead of us, this is not too early to begin preparations for such a momentous occasion. THE JOURNAL was asked to make a special anniversary issue on that occasion.

Ferd Weyerbacher, treasurer of the Association, has laid in a generous supply of red ink for use this coming winter; says he will need quite a bit when making his yearly report of the current financial picture. It is true that we have spent a lot of money this year of 1944, but it has been a busy year; we have met up with problems that never before have confronted us, and the solution of them has cost money — money well spent, we believe.

Sir Howard Walter Florey, famed British developer of penicillin, recently, in a nation-wide broadcast, paid tribute to the achievements of United States' science and industry in overcoming problems of large-scale production and clinical application of the life-saving drug. Here in the United States of America for a brief visit, the Oxford pathologist told in person, for the first time, his own story of penicillin's scientific history and its spectacular development as a life-saver at war and at home.

According to a press report, Doctor Ernest A. Hershey, of Churubusco, is taking his first vacation since he began the practice of medicine in 1918. He has been located in that community for some twenty-four years, and in all that period never took a real vacation. The doctor is spending some time in California, taking with him a son and a granddaughter. We trust that Doctor Hershey will thus develop the habit of taking a vacation annually; no medical man is fair to himself unless he gets away from the grind at more or less regular intervals.

Just what can be done to control inconsiderate patients is one of the big problems of wartime physicians on the home front. Many of these folk, even though they have been advised otherwise, continue to phone for house calls most any time during the day; whereas, if these calls were placed early in the morning the physician could plan his schedule and thus save many unnecessary trips to the same section of the community. Some time ago we cited an instance in which a physician in one of our larger cities had three calls from a district several miles from his home during one morning. Had these three calls been placed say at eight o'clock, one trip would have sufficed, the time saved being something to think about. Another irksome group is the "wait 'til the last minute" variety. They are the ones who come in just as you are leaving the office, saying, "I am lucky; got you just in time," when, as a matter of fact, the physician has a lot of things ahead of him at that moment. While we are at it we might also mention those who can come to the office during the day but wait until night, when working folk have the right-of-way. Verily, wartime practice has its ups and downs!

The *Indianapolis Star* reminds us that four of the signers of the Declaration of Independence were physicians: Josiah Bartlett, of New Hampshire; Lyman Hall, of Georgia; Matthew Thornton, of New Hampshire, and Benjamin Rush, of Philadelphia. Both Bartlett and Hall became governor of their respective states later on, while Rush became treasurer of the United States. The *Star* points out that "way back when" four American physicians took a stand for Democracy, while today some sixty thousand American physicians are fighting with the Army, Navy, and Air Corps for the preservation of that same Democracy. All the while, we have to fight a battle of no mean proportions right here at home, to preserve the decency and order which these service physicians left and which they hope to find upon their return.

There seems to be some misunderstanding regarding the group malpractice insurance, notice of which was mailed to all members recently. You are reminded that quite some time ago the House of Delegates ordered the Executive Committee to make a study of the plan, and, if thought advisable, to enter into a contract with some reliable insurance company covering the matter. After months of investigation the committee decided upon the plan outlined in the communication you recently received, and the insurance company has issued many policies under that agreement. The misunderstanding arises from the fact that some members thought that this closed their medical defense coverage, by the State Medical Association, and that unless they took out one of these new policies they would be entirely without protection. This is not true; Association medical defense carries on as usual. However, *this is for defense only*; the Association will pay the costs of such defense, but will not pay any part of a judgment, should one be awarded.

Dr. William T. Lawson, down Danville-way, had a birthday the other day; in fact, it was *quite* a birthday — his ninety-fifth, to be exact. Still in the harness, he no doubt is the oldest *active* practitioner in Indiana. He also is the oldest living alumnus of Wabash College, having been graduated from that institution in 1876. Speaking of "oldest," he is, of course, the oldest member of the Indiana State Medical Association. Contrary to his usual custom when a birthday rolls around, he did not mow his lawn on that date this year, due to the fact that the anniversary fell on a Sunday, hence, cutting the grass was out for the day. A man who has served as clerk of the session in a Presbyterian Church for a matter of some sixty-two years could hardly be expected to mow his lawn on a Sunday, even though it was his natal day. Doctor Lawson has served as secretary of his local medical society for so many years — we have forgotten the exact number — that he has become a fixture in that office. He also continues to serve as county health officer.

The Westinghouse Electric and Manufacturing Company recently announced that they had completed the ten millionth "insect bomb." This little gadget is designed to be used as an insect repellent and is in general use by our soldiers and sailors in the tropical areas. The manufacturers state that the bomb is about the size of the ordinary soup can and that it contains enough insecticide to "de-bug" one hundred fifty Army pup tents or fifty giant bombers. Just another of the many phases of the war about which we had not heard.

Dr. Irvine H. Page, for many years head of the Lilly Research Clinic at the Indianapolis City Hospital, has resigned that position, and on January first will head a like group at the Crile Clinic, at Cleveland. Dr. Kenneth Kohlstaedt, who for some years has been working with Doctor Page, will take over the duties of Director of the Lilly Research Clinic. Doctor Page is a son of the late Lafayette Page, of Indianapolis, who was nationally known as a leading laryngologist, his work on cancer of the larynx having received favorable notice throughout the country. We regret to have Doctor Page leave Indiana, where his work has attracted much attention, his book and his papers being well received in American medical circles.

The Special Reference Committee of the House of Delegates appointed to consider the plan for reorganization of public health activities in the State of Indiana, submitted by the State Board of Health, came through with a workman-like job. The committee was headed by Dr. Harry Ross, of Richmond, chairman, along with E. R. Clarke, of Kokomo; C. M. Donahue, of Carmel; Naomi Dalton, of Bloomington, and W. A. Thompson, of Liberty. They invited representative and interested local and state health officers to participate in their deliberations, and went through the plan word for word. The resulting plan is one that calls for long-time planning, but is forward looking in every degree. It is significant that it calls for local control of our health departments, the State Board of Health and the United States Public Health Service to serve in an advisory capacity only. It is a plan that calls for the funds to be provided by the local units served, with state assistance when necessary. Use of federal funds and personnel is condemned. Unquestionably, if this plan is carried out it will provide the State of Indiana and our local units with health departments meeting the highest standards and, *most important*, they will be controlled by the localities they serve. This committee did good work, and Dr. Ross and his colleagues deserve high commendation. Every member of the profession in the State of Indiana should carefully study the plan and exercise vigilance in seeing to it that it is carried out without destructive changes. It is a subject that is vital to all of us. Regimentation in public health is no more to be desired than is the regimentation of medical practice.

Ponder the case of spinach, long recommended by dietary experts for its iron content. Children, in particular, were fed tons and tons of this article of food, all too often much against their wishes. Just when almost everyone had become spinach-minded, along comes a group of scientists, advising that we are all wet about this thing, that spinach hampers growth of teeth and bones. They also state that the same goes for Swiss chard, beet tops and the like. However, the problem is not so much a personal one as in former years, since we did not plant any spinach.

The New York State Journal of Medicine, in its issue of October first, carries the following editorial, which we deem of sufficient interest to the average physician to warrant reproduction:

INSURE YOUR SELF-RESPECT

"We approach the time when, once every four years, the country works itself into a pre-election froth. Authentic polls of the voters tell us (up to the moment the ballots are counted) just what is going to happen. The simplest action of any public official is scrutinized for political significance. The newspapers and the radio become profound political oracles. And the elected representatives of the people mend fences furiously throughout the length and breadth of the land, so that no voter shall stray from the corral.

"At such a time one is particularly impressed with the wisdom of medical leadership which, so far, has kept the profession free of political alliances or entanglements of any kind. Whatever party wins at the polls, whatever administration we may have to endure for another four years of broken promises, higher taxes and gobbledygook, medicine at least can go about its business relatively unhampered by commitments to anybody but the sick. We say 'relatively' because recently the fashion seems to be for political administrations to annoy the profession with proposals to come and play in the government backyard, and perhaps to dabble around a little with the boys at the public trough.

"Fortunately, even though the public health is at a high level, there is still a great deal to do to improve it. This is our concern. It is a full-time job. And at the moment, election or no election, come hell or high water, an important part of that job is the promotion of voluntary medical expense indemnity insurance. It doesn't matter in the least what party wins the election. The country has magnificently survived and with patience endured all kinds—good, bad, or indifferent.

"But unlike political administrations, medicine has to make good *all the time* or the people want to know how come? And the people will not take hokum for an answer. The Medical Society of the State of New York is officially committed to the proposition of voluntary medical expense indemnity insurance for the betterment of the individual and the collective health. It must make this system of self-respecting prepayment for medical care work with the help of the people themselves and free from political obscurantism. It will be quite a job, especially since we of medicine are shorthanded; but no matter, we can do it and call it by its right name into the bargain. Medicine is not hampered by the necessity for fence mending, elections, or any commitment to compel anybody to do anything about medical indemnity insurance, or the "political angles" inherent in any government-controlled project.

"When medicine deals directly with the people themselves on a voluntary basis, there is safety and security for both."

Convention Notes

The 1944 convention will go down in our book as one of the best ever—full of color, things moving right on schedule, an unusually good scientific program—all combined making a good meeting.

* * *

These early committee breakfast hours are most trying for the younger set; they come in — if they get there at all — with hair tousled, eyes bleary, and a general appearance of having just gotten out of bed. On the other hand, the oldsters can take it; they are there ahead of time, all spruced up from the morning bath and shave, and with a clean shirt.

* * *

Major Clarence Munns, formerly executive secretary of the Kansas State Medical Association but now a part of General Grant's Washington office, was among the visitors to the convention. Notwithstanding the dignity of his uniform, Clarence still wears the "Million Dollar Smile," which made him famous in medical circles in the days before the war. He always liked Indiana, and went so far as to say that our September JOURNAL was the best thing he ever had seen.



President Oliphant discussing medical problems with his successor, Dr. N. K. Forster.

* * *

President Oliphant did a swell job all through the convention — in fact all through the year. But it was in the House sessions that he showed a marked ability in keeping things in line and keeping the speakers right on the subject under discussion.

* * *

General Grant flew in for the Tuesday-night smoker with a full crew, all decked out in full regalia; never saw so many majors, lieutenant colonels and colonels in one group in all our born days. Tom Hendricks acted as chief host, flopping about from one to another, trying to talk to every member of the party at one time, and making a pretty fair job of it at that. (We better quit talking so much about said Tom; first thing we know he will be saying to himself, "If I am *that* important, maybe I'd better ask for a raise.")

The Murat Temple lends itself very well to such a convention as ours, but the criticism most commonly heard was that it is quite a jaunt from the hotels, and the newly-enforced traffic rules slow up one who is accustomed to walking such distances.

* * *

Supplemental reports in the first meeting of the House of Delegates are too often not just that; they are a re-hash of the regular report which already has been published. Our conception of a supplementary report is that it is one which brings up some matter that had been omitted from the formal published report.

* * *

We had to trek all the way down from Hammond to learn that President-Elect Forster is an ardent amateur photographer. He was exhibiting some of his art treasures at the Executive Committee meeting the other night, almost breaking up the continuity of the meeting. He features both still life and action pictures, some of which show much promise. Yes, a versatile guy is always unpredictable; even his closest friends never saw him trudging about town with a camera.

* * *

A note from Captain Dick Graham, also from General Grant's office, in Washington, indicates that Dick would very much like to have been with us. For many years he served as executive secretary of the Oklahoma State Medical Association.

* * *

In our opinion the Scientific Exhibit, under the direction of Drs. C. G. Culbertson, K. G. Kohlstaedt, and Ernest Rupel, was one of the finest exhibitions ever presented at our annual conventions. While not as large as in some years past, every subject presented had a marked current interest which accounts for the unusually large number of visitors who stopped to view the whole display. Another thing that made it more popular was the fact that it was not hidden in an obscure corner so badly crowded that one could hardly find his way around. All credit to the committee!



Some of our eminent guests

Left to right—General David N. W. Grant, Dr. E. L. Henderson, and Captain Frederick Ceres, U.S.N.



A Yankee among Hoosiers

Left to right—Dr. Floyd T. Romberger, Dr. Frank H. Lahey, Dr. W. H. Howard, and Dr. Jesse E. Ferrell.

We tried to pull a fast one on General Grant, but that old war horse was too cagey for us. He told us that he had admired the September number of *THE JOURNAL*, whereupon we advised him that the front cover of the copy sent to him was a hand-painted affair, and that we had done the thing ourself — didn't get very far with it, however.

* * *

What with the initiation of members of the Association into the "High Hat Club" and the entertaining of the Army Air Corps "Brass Hats," Tom Hendricks had a wonderful time.

* * *

Yes, we wore our little "Tom Dewey" moustache to the convention; acquired it while in the wilds of Canada this summer. W. R. Davidson, with whom we have been intimately acquainted over the years, really passed us up on the street, then turned to take a posterior view before he recognized us. The little lip adornment is just another instance of what a man in his dotage is likely to do.

* * *

Lucille Kribs, assistant secretary of this "Unit of Unit of Medical Wisdom," refused to be perturbed by anything. In the midst of a committee meeting or in a House session Tom always is misplacing some paper or memorandum. He says, "Miss Kribs, where is so and so?" and that young lady produces the thing, instantan — used to it, you know.

* * *

While not the actual handler of Association funds, Romberger, chairman of the Council and a co-signer of all checks issued by headquarters, is the real watchdog of the treasury; he scrutinizes every item of every bill presented, and woe be to the member who presents an expense account in which *every* item is not exactly right. "Rommy" actually looked over the items on one's dinner check issued by the Monon Railroad, asking why this and why that. He really is good at this job.

After Jesse Ferrell, of Fortville, had been named as President-Elect, Boss Oliphant named George Daniels as chairman of a committee to escort the newly-elected gentleman into the sacred precincts of the House. George, in accepting the honor, said, "What sort of lookin' guy is he?" just as if he had not known Ferrell for years.

* * *

The big pile of photo flashlight bulbs lying about the Murat Temple may be charged to Bill Wishard, who still cannot resist getting candid shots of those in attendance. For such a big chap he sure can sneak up in the most approved Indian style.

* * *

Miss Rokke, our valuable assistant, had her hands full, as usual. What with assigning reporters to the various meetings, keeping right after papers as they were read, and keeping one eye on the editor to see that he was doing his stints properly, she was a busy person — and liked it.

* * *

Danieleski, of Gary, always the politician — Gary men are just that way you know — came up with the question, "Well, Shank, what's the politics?" He seemed surprised when we told him we know nothing about that phase of the convention, that we were too darn busy collecting material for notes to pay any attention to politics.

* * *

Davy Crockett appeared before the Executive Committee meeting to get some information regarding the Health Insurance Committee report; seems he had been named as head of the reference committee to which this report was referred. He said after the meeting that although his committee had not met as yet, he already had enough material for an address to the House of Delegates covering a period of an hour or more. However, some of his friends prevailed upon him to have mercy, and at this writing the whole matter is in the air — we await this meeting of the House with much trepidation.

"Mitch" came into the Council luncheon quite late; said that for many years he had depended upon Alexander to get him ready for the trip, and that he was not used to being on his own.

* * *

The Commercial Exhibits were tops, the arrangement being all that could be desired — plenty of space, good lighting, and a good crowd to "shop" the place. Free Coke, free Seven-up, and free Milk did a lot toward making folks happy.

* * *

Herman Baker reports that he still is living in the "woodsy" country, north of Evansville, and that he recently has been fortunate enough to have city water piped in, although rain water continues to be available.

* * *

The Murat Temple was filled to capacity with "healers" Tuesday night, with the medical group in the north end of the building and the Scientists occupying the theater for a lecture. The "healers" seem to have it.

* * *

The annual smoker is one occasion when doctors really "let their hair down" and become normal human beings. They can, and do, have fun out of most anything. They gang up and talk of old times, eat a little — some of them a lot — drink a bit, smoke the free cigarettes — not so free this year — and generally disport themselves.

* * *

Our better half, long accustomed to the kaleidoscopic changes that come with every annual convention, when we have early breakfasts, late dinners, and a lot of going about, finally is complaining that life at these meetings is getting a bit too complex. Therefore she ditched a part or two of the program for the ladies, and spent the time with some of her former cronies in her old home town, even had a dinner session with her old Shortridge High School gang.

Frank Lahey was "grounded" in Tulsa and could not get to Indianapolis in time to address the dinner guests. Ross Sensenich acted as pinchhitter.

* * *

Miss Stanley, the assistant at the JOURNAL headquarters, had her first real experience in a state convention; Miss Rokke showed her the ways 'round and turned over to her several chores. Miss Stanley "did noble" for a novice.

* * *

"Sam 'n Katharine," the two Shelbyville standbys, were not with us this year, the first time in our memory they have missed a meeting. We heard many members asking about them. THE JOURNAL wishes for them a speedy recovery, and that they may again grace our conventions.

* * *

One of the new members of the Council found himself in a dilemma, just had to have a cigar, and none was immediately available. He asked us about it, and fortunately we were able to supply him with one, thus making a complete day for another man.

* * *

Frank Lahey evidently had lost his glasses when he arrived at the Thursday morning session of the House, or perhaps he just didn't talk long enough to get them out. You will recall that at a former visit, when he made a formal dinner address, he tickled his ears, nose, and chin with the temples of his glasses while he talked.

* * *

According to no less an authority than Creighton Barker, executive secretary of the Connecticut State Medical Society, Tom Hendricks, known to most members of our association, has a new title, "The Pin-Down Boy." Creighton says he knows no other man with such a proclivity to "pin down" a fellow on most any statement he might make. Come to think of it, we believe the new title is well deserved, as we have been "pinned down" every time we enter into conversation with the Blond Boss.



Annual Session Scenes

Left to right—Major D. A. Covalt; Captain Joseph Hamilton; Second Lieutenant Veronica Savinski, of Air Force Nursing Staff; and First Lieutenant E. E. Speer, of Stout Field.

Left to right—Dr. E. M. Shanklin, Dr. Marlow Manion, Dr. Bert Ellis, and Dr. C. G. Culbertson.

Left to right—Dr. V. L. Turley, Dr. D. F. Cameron, and Dr. W. T. Lawson.



Who wouldn't smile?

Cleon Nafe and "Davy" Crockett receive First Aid from an Air Evacuation Flight Nurse.

Henry Eggers, one of Hammond's younger set, broke in on the credentials committee. That he soon learned the ropes is certain, since veteran Amy, of Corydon, had him under his wing.

* * *

For the first two days of the convention we missed Mike Shellhouse, the half-pint size "Mayor of Glen Park," a Gary suburb. Mike is always on the job at these meetings, and this year, as usual, was full of the old "P and V."

* * *

The program said that the registration would open at the Murat Temple at 8:00 A.M., Tuesday morning. We asked Tom about it, and he said, "Yes, of course it will begin then." We were more than a bit skeptical about anyone appearing at that hour, even Tom and his gang, so we went over, and "dog-gone" if they weren't there, every one of them—all six of the very attractive young ladies, plus our own Miss Reid from headquarters, who for several years past has been the directing head of the registration bureau. And does she know her stuff?—just let a member of the House of Delegates or an officer of the Association appear in the offing and Elsie digs down and comes up with the proper badge, already made out for the 'big-shot.'

* * *

Once more, referring to gustatory or Epicurean matters, at the annual banquet the *pièce de résistance* was a filet mignon, delightfully tender. But the amazing thing about it was that which was served with it, in separate deep dishes—fried onions! Can you imagine that? Never heard of such a thing in all our born days, *fried onions at a banquet*. And did they sell? We'll say they did. Looking over several tables we failed to see one plate that was not heaped with this delicacy. And the Air Corps "Brass Hats" went for 'em, too, in a big way. It takes the Hoosier state to set new styles and new customs, and we would not be at all surprised to learn that henceforth fried onions will appear on the menu of all state association banquets.

George Daniels darn nigh slipped up on his copyright to "I move we do now adjourn," at the close of the first session of the House of Delegates. Having no idea that adjournment time was anyway near, he slipped into the back part of the theatre for a little snooze, waking up barely in time to "hold his rights."

* * *

French Lick in 1945 is the program, which pleases a lot of Indiana physicians. While it is true that the attendance is not so large and the exhibitors not so numerous, there is something about the Southern Indiana atmosphere that is attractive to every one of us. No other meeting place was suggested, which indicates that most of the delegates long since had decided on French Lick.

* * *

The annual dinner was a real success, at least from a gastronomical standpoint. We do not recall ever having been served a better dinner at a similar function. 'Nother thing we noted, with quite some pleasure, was "four days in Indianapolis and not a single chicken in sight"; that is, we were not served chicken at a single meal in all that time. They seem to have gone in for pot roast for luncheons down there, which to us is far superior to chicken.

* * *

For many years the United States Senate held the title, "The Most Deliberative Body in the World," and it was presumed that this title would remain intact until the end of time. However, we have discovered a new claimant to the title, and in our humble opinion the new owners will hold on for some time to come. The Executive Committee of the Indiana State Medical Association is, without question, *the* deliberative body of the nation; that group can hang on to one topic longer than any other organization extant, and when they finally have finished the subject under consideration it really *is* finished—there is nothing left to be said about it.

* * *

The first man we saw on the exhibit floor, Tuesday morning, was the somewhat venerable Dr. William T. Lawson, of Danville. Recently we "gave away" his age, ninety-five. He has been attending state medical conventions since 1880, and says that while he does not hear so well these days, he gets much pleasure out of these annual affairs, meets a lot of people he knows, enjoys the commercial and scientific exhibits, and in general has a good time. He was a little perturbed when the young lady in charge of a cigarette exhibit asked him to "sign up," that he might receive a gift of cigarettes later on. He said he never had smoked in all his ninety-five years.

A derelict from "other days" wandered about the exhibit floor, one of those "mental cases," but when he was "himself" he was a most ardent attendee at our annual meetings.

* * *

The Woman's Auxiliary turned out in full force. They had a good program, which was run off in veteran style. The Wednesday morning breakfast was exceptionally well attended, and all the entertainment features were carried out as planned. We just can't do much *with* these "wimmen" of ours, but, heck! what could we do *without* them?

* * *

After a diligent search, plus many inquiries, we finally found an Indianapolis spot where one may get fresh oysters on the half-shell; there is one drawback, however, in that the oysters served are *not* cold, thus destroying that certain flavor that only a bit of chilling gives an oyster. Oh, for the days of "Pop" June, where one could get most any kind of sea food!

* * *

The Indianapolis pigeon colony seems to be thriving, there being hundreds more of the "bird-pests," as they are called, locally, than at former visits to the capital city. We noted, up in University Square, that almost every afternoon an elderly lady brought at least a half bushel of grain and scattered it on the grass. Hundreds of pigeons, probably knowing of her habit, soon gathered, and the grass, such as it was, was literally covered with them.

* * *

At the second meeting of the House of Delegates a chap tried to horn in on the prerogative of George Daniels, the best "seconder" in the country. You'd never guess who had such effrontery — no less a person than the quiet, orderly Charley Combs. Yes, Sir, Charley popped right up and began a seconding motion, whereupon George rose right up and said, "Now, Charley, you know better than that," and Charley, much discomfited, sat himself down and left the matter to George.

* * *

There was much speculation regarding the "Pin-Up Gal" used as the front cover for the August number of THE JOURNAL. The editor had nothing to do with it, it being a plan conceived and executed by the managing editor and the assistant editor. However, they may take a fall when they see the "Pin-Up Boy" picture now being generally adopted by the nurses in service. It is the likeness of none other than Bob Doty, of Gary, long known as the "Adonis of the Dunes." Several editions of this photo have been run off, and the demand still increases. Bob will be known throughout the world if this thing keeps up.

The inevitable, irrepressible "gallopin' dominoes" appeared before the buffet luncheon part of the smoker had been completed; someone rolled a pair of dice across a table, emitting the wish, "Come, Phoebe," and in a trice he had a lot of customers.

* * *

We hope that we may be permitted to stick around until the boys come home, and attend their first state convention. Our guess is that they immediately will take over, and that we old-timers will take a back seat — if we get a seat at all. At that, we will be plenty glad to have them back, but we would like to see the show — it will be *good*.

* * *

The new downtown traffic gals sure are intriguing. We like to hang around the corners for a bit and watch them work. And are they efficient? — plenty. They not only whistle at offenders but march right out and get them, and waltz them right back from whence they came, there to await the proper signal. We did not essay a single crossing this trip until the proper sign showed up.

* * *

What has become of the old convention badges? We presume the answer will be "gone to the war." These old-timers were good-looking, printed on blue silk ribbon with gold ink, and very decorative. The officials were honored by having their name and title imprinted thereon. The kids at our house used to scramble for the badge, no sooner than we had arrived at home, and would wear it to school as long as it held up. Verily, the old days are gone.

* * *

Miss Rokke, who has been with THE JOURNAL for several years, is enthusiastic about the outlook for the continued success of our magazine. Even with almost a thousand of our members in service we manage to supply enough scientific articles, along with the material in the other departments.

* * *

We didn't see this one happen, but one of our agents tells it as being the truth. Karl Ruddell, inveterate devotee of the pipe, was told that at one of the commercial booths they were giving away tobacco for one's pipe. Sure enough, they were; you just walked up, filled your pipe and walked off smoking contentedly. After a few minutes Karl would return — he liked the free tobacco. Then he came back, and again he came back, and finally the gal in charge handed him the remainder of the pound package, saying, "Doctor, I fear you will not see the rest of the exhibits, you had better take this with you" — and Karl did just that, so our agent says.

John Ray Newcomb — alias, "The Bishop" — had an exhibit all his own, that having to do with the Association broadcast. He was the only member of the crew that appeared at the exhibit, the others apparently being content with having their pictures on display.

* * *

Looking out over University Square before sun-up usually is a sight worth seeing, but the cold, gray, almost drab mornings this year added little to romanticism, even though just across the corner from the Club stood the former home of our better half — in fact, we were married there more than forty-two years ago.

* * *

We occasionally have used the term, "one of our agents," in compiling these notes; we hasten to say that this is not original with us. For some years we have been reading Lowell Nussbaum's daily column in the *Indianapolis Times*, and he uses that term very commonly. Thus, we make our most abject apologies to the writer of that very entertaining column.

* * *

A picture, taken at Stout Field, shows Floyd Romberger with coat collar turned up, black hat set at just the proper angle, and with hands folded on his bosom—looks "for all the world" like a priest. The caption below the picture reads, "Dr. Floyd T. Romberger, Lafayette, chairman of the Council of the Indiana State Medical Association, flanked by *two* comely ladies, which makes us pretty sore. There were *three more ladies* in the group, one of whom happened to be my Mama—and she's pretty darn comely, too. These pictures, by the way, were printed in *The Fielder*, organ of Stout Field.

* * *

One of our agents told of an amusing experience at Stout Field, where a considerable number of convention attendants had gone on Thursday afternoon to witness a demonstration by the Army Air Transport Command. On arrival at the field there was a call for twenty-one volunteers to act as "casualties," they to be carried aboard a transport plane used for bringing patients to this country from foreign battle fields. As is always the case, there was one grand rush for the honor, and after these doctors had been laid out on the litters, with their hats neatly placed across their breasts, they were carried aboard the plane, their stretchers being arranged into tiers of four each. Then the plane was opened to visitors who filed past to see just how such things were done in real life. Well, these volunteers remained in their bunks for some two hours, missing most of the show on the outside and doing a good job of sweating and being downright uncomfortable ere they were released. And, as you will recall, that Thursday afternoon was really a hot one. Betcha the next time there will not be such a scramble to be a hero!

In a picture taken at Stout Field, while the medical group was out there to witness a demonstration, Tom Hendricks is shown alongside some sort of a plane, flanked by General Old and Colonel Benford, Command Surgeon. Tom was wearing his usual smile, but there is something awry with the general setup—looks as if his galluses had bust loose and that he was about to lose his pants.

* * *

While we do not make a business of eating, such as we used to do, and while we long since have accorded Bill Brooksher, secretary-editor of the Arkansas State Medical Society, first honors in that line, we still do enjoy a "Hoosier Breakfast," meaning one where a fellow really eats — not the hot water, toast breakfast affected by so many doctors. So, when we sit down to a breakfast table with others and find that they, too, really eat a breakfast, we find much satisfaction in it. The other morning we went to the dining room in the Indianapolis Athletic Club, and sat us down with Jake Oliphant and Joe Crowder, each of whom proceeded to order No. 5, with some extras. Be it said that this same No. 5 has been a regular breakfast habit of ours for many years, so we at once warmed up to the program. A moment later, along came Floyd Romberger and joined up with us, telling the waiter "Just bring me No. 5." So ended a perfect morning.

* * *

The task of getting pictures of the official family for the pre-convention number of *THE JOURNAL* becomes harder and harder each year; someone always is recalcitrant. This time it was Minor Miller, of the Editorial Board. He just procrastinated day after day, and when he finally did trek up to the photographer he was told that there was a war on and that even photographers were unable to get their stuff out in regulation time, so that was that. However, Miss Rokke kept after Minor until in deep desperation he walked into the Bertillon room at the Evansville Police Headquarters, demanding a picture right now. The operator, being in rare good humor that day, posed Minor in the regulation gangster style, number and everything. But to save his face, as well as not to clutter up the pages of this epistle of education with gangster-style pictures, we have deleted the number, but the picture remains "as was."

* * *

Rather than being perturbed by his "rogue's gallery" picture, Minor Miller seemed highly pleased with its reception. He said that he had had many compliments on the originality of the pose. (Nothing to be cocky about, we opine; police photographers insist on having their own way about such things.)

ARE YOU A "HOOSIER HIGH HAT?"

Some four hundred Indiana doctors and their guests were initiated into the mysteries and psychical subtleties of the ultra-secret and highly exclusive "Hoosier High Hat Club" during the state meeting. Our special staff photographer, William Wishard, "crashed" the "torture chamber" and has come forth with this intimate series of highly illuminating candid-camera close-ups.



Three Prospective Victims.
Foreground left to right—C. L. Williams,
E. Vernon Hahn, and John R. Porter.

A few of the hopeful but somewhat
dubious inductees.



Relaxers giving 'em the pre-induction
works.



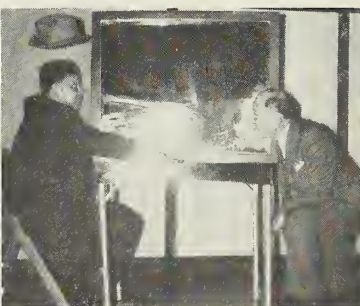
"Look at Bert and blow, Cleon!"
Bert Ellis, Cleon Nafe, and Gordon Batman.



Colonel Don Hildrup kneeling on sacred
cushion—Ellis functioning as "Grand High
Topper" of the order with Batman
assisting.



"Blow hard, Bob!"
Hubert Collins and Robert Moore.



"Thar she blows!"
Hubert Collins and Reuben Solomon.



"Electronics and radar does it, doctor!"
Hubert Collins, Byron Rust, and J. J. Littell.

Walter Moenning, Gordon Batman, Bert Ellis, Tom Hendricks, et al., put on an impromptu show during the convention that was quite novel and distinctly an Indiana show—"THE HOOSIER HIGH HAT CLUB"—a new club indigenous to Indiana, said to have had its inception in the mind of a Terre Haute newspaper man. The organization has a ritual which, although short, is of an

interesting character, has an official badge and all that, and apparently has a popular appeal. Tuesday night, at the smoker, it all but stopped everything, so many wanted to join up. The total initiation fee and dues is two bits; the promoters said the receipts were to go for a worthy cause, but we have our doubts as to that. We joined the order on September first, and at that time there were neither dues nor initiation fee, so write your own ticket.



President's Page



A special session of the House of Delegates has been called for Sunday, November 12, 1944. The purpose of the session is to consider the report of the Reference Committee on Health Insurance. The substance of this report is expressed in these words:

"Your committee, therefore, recommends and moves that the state association form and operate its own non-profit indemnity plan of health insurance."

Three separate questions are contained in this report, and each of them is of the gravest importance.

1. Shall a prepayment plan of health insurance be endorsed by the Indiana State Medical Association?
2. If the answer is "Yes," shall it be a service plan, or an indemnity plan?
3. Shall the Indiana State Medical Association own and operate the resulting insurance business, or shall it be left in the hands of an insurance company or insurance companies?

From more than two hours of debate during the second meeting of the House of Delegates, October 5, it was evident that there is a wide diversity of opinion, and some misunderstanding of all three of these questions. For this reason the delegates voted to defer the discussion until November 12 in order that they might have time to go home and talk it over with their county societies. However vital the final decision may be, it is equally important that every member of the society understands the meaning of the proposed steps.

For a long time many doctors have believed that a prepayment health insurance plan, operated either by the medical societies, or sponsored by them, would serve to discourage socialized medicine. A few state societies have inaugurated such plans, and several others are considering them.

The first question is whether such a plan is applicable to the State of Indiana. All possible effects that such a plan would have upon the present method of practice should be considered. Will prepayment health insurance be a help or a hindrance to the majority of doctors now in practice, or to the many doctors who will come back from the war? This information can be had only from localities where health insurance plans have been in operation long enough to evaluate their results. The Permanent Study Committee on Health Insurance has gone over the available data from these localities, and should be able to present the known facts.

If the delegates vote to adopt some plan of insurance, they should decide whether it should be a service plan or an indemnity plan. There should be a clear understanding of just what is meant by each of these terms; what they mean to the doctor, and what they mean to the person who buys the insurance policy. Finally, it must be decided whether it is for the best interests of all concerned to have the state association own and operate the company that is to provide the insurance. Here again the data is meager, but all known facts should be assembled and studied. Any conclusion reached should reflect the best judgment of a majority of the doctors in Indiana.

These are the problems awaiting solution at the special session of the House of Delegates on November 12, 1944.



SPECIAL SESSION OF HOUSE OF DELEGATES

A special meeting of the House of Delegates to consider Prepayment Insurance Plan for Indiana will be held November 12, 1944, at 9:30 A.M., Ballroom, Athletic Club, Indianapolis.

DISCUSSION OF SERVICE AND INDEMNITY PREPAYMENT MEDICAL AND SURGICAL CARE PLANS

1. A Discussion of the Proposed Medical Plan Submitted by the Permanent Study Committee on Health Insurance, by F. S. Crockett, M.D., Lafayette, page 615.
2. Evolution of Michigan Medical Service, by Jay C. Ketchum, Detroit, Michigan, page 617.
3. Voluntary Medical Service Plans in New Jersey—A report to the Physicians of Indiana, by Norman M. Scott, M.D., Newark, New Jersey, page 620.
4. California Physicians' Service, by A. E. Larsen, M.D., San Francisco, California, page 622.
5. Outline of types of Medical and Surgical Prepayment Plans, page 614.

CALL FOR SPECIAL SESSION OF HOUSE OF DELEGATES

In order to consider the adoption of a prepayment medical and surgical care program by the Indiana State Medical Association, a special meeting of the House of Delegates will be held in the Ballroom at the Indianapolis Athletic Club, Sunday, November 12, 1944, at 9:30 A.M. This meeting is called by Dr. J. T. Oliphant, president, as a result of the action taken by the House of Delegates during the ninety-fifth annual session of the Indiana State Medical Association, in Indianapolis, last week. At this meeting the House of Delegates discussed the question of health insurance, but due to lack of time and a desire by the delegates to become informed more fully upon the subject of prepayment health insurance in general, and the difference between indemnity and service plans in particular, and other details of the subject, the special meeting was voted.

The question before the House when it assembles on November 12 for this special meeting will be the consideration of the report of the Special Reference Committee on Health Insurance, which is included herewith.

Background

After a year's study, the Permanent Study Committee on Health Insurance, headed by Dr. W. H. Howard, of Hammond, recommended to the House of Delegates, at the first meeting on October 3, during the 1944 session, a program which was substantially the Michigan Medical Service Plan. This report of Dr. Howard's committee was referred to the reference committee headed by Dr. F. S. Crockett, of Lafayette.

This special reference committee held hearings during the state meeting last week, and not only considered the report of Dr. Howard's committee but also studied the subject from all angles and submitted the report mentioned above, at the second meeting of the House of Delegates on October 5, 1944.

Suggestions

1. Read the original report of the Permanent Study Committee on Health Insurance (the Howard committee) printed on pages 501 and 502 of the September issue of *THE JOURNAL* of the Indiana State Medical Association. (This also appeared on pages 71 to 75 of the *Handbook* of the House of Delegates.)

2. Then read the enclosed report of the Special Reference Committee on Health Insurance (the Crockett committee).

3. Hold a meeting of your group to discuss this subject. Perhaps it would be well to have some member from these two committees, who have given special study to the problem, present to aid in the discussion. The members of these committees follow:

Regular Permanent Study Committee on Health Insurance:

Chairman, W. H. Howard, Hammond
W. U. Kennedy, New Castle
Lynn W. Elston, Fort Wayne
A. C. Yoder, Goshen
Clay Ball, Muncie
A. P. Hauss, New Albany
C. P. Fox, Washington

Special Reference Committee on Health Insurance:

Chairman, F. S. Crockett, Lafayette
C. B. Paynter, Salem
J. H. Weinstein, Terre Haute
T. Z. Ball, Crawfordsville
W. L. Portteus, Franklin

4. This is perhaps the most important problem to come before your society and the Indiana State Medical Association in years. Although it is a difficult and complicated subject, it is the hope of your officers that every consideration be given to it and that it is not brushed off with a cursory or a casual "Yes" or "No."

5. Officers of county and district medical societies and committeemen are invited to attend the November 12 meeting and to listen to the House of Delegates' discussion.

6. If you have any questions or suggestions, let us know immediately as the time for obtaining additional information is short.

EXECUTIVE COMMITTEE

C. A. NAFE, M.D., *Chairman*,
C. H. McCASKEY, M.D.,
J. T. OLIPHANT, M.D., *President*,
N. K. FORSTER, M.D.,
F. T. ROMBERGER, M.D.,
THOMAS A. HENDRICKS,
Executive Secretary.

(Minutes of House of Delegates, containing discussion that took place on this subject at the second meeting of the House, is carried in this issue of *THE JOURNAL*.)

SURGICAL AND MEDICAL PREPAYMENT PLANS

Even at the risk of over-simplification, here is a comprehensive outline of the principal types of medical and surgical prepayment plans now in operation or under consideration in various states. It is hoped that this may serve as a guide to the members of the House of Delegates when they consider the question of Prepayment Insurance Plans at the special meeting of the House of Delegates, on November 12, 1944.

Type	Where Instituted	Remarks
I. Service —Covers surgical, obstetrical, and medical service in hospital and some emergency surgical and medical service outside hospital. State society would form own Mutual Insurance Company. Has income limits for those who may participate—acts as indemnity plan for those insured above these limits.	Michigan New Jersey California	Indiana organization would have its own separate Board of Directors, but all administrative details and selling is done by Blue Cross organization. This is the plan submitted by Permanent Study Committee on Health Insurance, Dr. W. H. Howard, chairman. See September JOURNAL, page 501.
II. Indemnity —Covers surgical, obstetrical, and medical service in hospital. State society to form own Mutual Insurance Company.	Under consideration in Indiana	Submitted by special Reference Committee on Health Insurance of House of Delegates, Dr. F. S. Crockett, chairman. See report of Reference Committee in this issue of THE JOURNAL.
III. Indemnity —Covers surgical, medical, and obstetrical care in hospital.	Connecticut	Fees and details to receive final approval by Connecticut State Medical Society. Policy to be written by commercial company.
IV. Indemnity —Covers surgical, medical, and obstetrical service in hospitals—work with Blue Cross Plan by commercial company especially created to do this.	Under consideration in Wisconsin, Cincinnati and other places by Blue Cross	State society to have control over medical and surgical features of plan in method to be determined by it.
V. Indemnity —Covers surgical, medical, and obstetrical services in hospitals.		Commercial company approved by medical society, but physicians have no voice in its operation.
VI. Indemnity —Stock insurance company organized to write medical coverage on a cash indemnity basis.	To be presented to Council of Ohio State Medical Association on November 12, 1944, for approval.	Control of company to reside in the medical profession of Ohio. Blue Cross of Ohio will be asked to cooperate.
VII. Indemnity —Field left open to commercial companies without any voice in procedure by the Indiana State Medical Association or the Blue Cross.		

Definitions: "Service" means that payment will be made direct to physician.
 "Indemnity" means that payments are made to patient.

This does not include plans that are operated in cooperation with the government, such as are in effect in Rhode Island and planned for New York City.

REPORT OF THE SPECIAL REFERENCE COMMITTEE ON HEALTH INSURANCE

Your Reference Committee has carefully read and discussed the report of the Permanent Study Committee on Health Insurance as it appeared in the September issue of *THE JOURNAL*. We wish to commend the committee for the excellence of its report. It is evident that a large amount of time and study was devoted to its preparation. Your Reference Committee was in session all day yesterday, hearing those interested in this report.

The opinion expressed was overwhelmingly in favor of some plan being proposed by this session of the House of Delegates. It is recognized that the profession is not of one mind concerning the proposed medical service plan. Thinking along this line has fallen largely into three groups, the first group favoring the formation of a service plan by the physicians themselves, such as that published in the report of the Permanent Study Committee. The second group believes that an indemnity type health insurance should be formulated. In both instances the opinion of those appearing before the committee was that whichever type is agreed upon by this House of Delegates, the corporation formed to carry on the business should be organized, owned and operated by members of this association, with the advice of the Council. There is a third group who believes that the association should enter into no plan whatsoever. While opinion differs as to the plan we should adopt, the majority favors an indemnity form of insurance.

The Permanent Study Committee on Health Insurance, after long study and canvass of similar activities in other states, proposed in their report that we organize our own non-profit corporation to provide medical service to certain wage groups. We recognize that such medical service groups have worked very well in other states, but we feel that the majority of those who appeared before our committee favored an indemnity form of insurance for Indiana. This method of direct payment of benefits to beneficiaries is in line with the accepted principles of physician-patient relationship that has always been the accepted policy of this association.

Your committee is of the opinion that the financing of the plan adopted should be carried out without the use of funds at present in the treasury of the state association.

Your committee therefore recommends and moves that the state association form and operate its own non-profit indemnity plan of health insurance.

Second, your committee recommends the appointment by the president, with the advice of the Council, of a committee to carry out the provisions of the foregoing motion.

F. S. CROCKETT, *Chairman*,
C. B. PAYNTER,
J. H. WEINSTEIN,
T. Z. BALL,
W. L. PORTEUS.

A DISCUSSION OF THE PROPOSED MEDICAL PLAN SUBMITTED BY THE PERMANENT STUDY COMMITTEE ON HEALTH INSURANCE

F. S. CROCKETT, M.D.

LAFAYETTE

We attempted to obtain a report from Connecticut on the Indemnity Plan that is being considered by the Connecticut State Medical Society. In answer to our request, Dr. Creighton Barker telegraphed us as follows: "Prepaid Medical Plan not yet operating in Connecticut. Published discussion of plan premature." Hence, we asked Dr. F. S. Crockett to prepare a statement, giving his viewpoint of those that prefer an Indemnity to a Service Plan.—Editor's Note.

For those who believe that the profession should stick to its knitting and do nothing else, this discussion means nothing. Those viewing the changing world about us, seeing what is happening to agriculture, business, labor, finance, and manufacturing these past few years can not expect medicine to remain untouched by the ebb and flow of social movement that has engulfed the rest of the world.

The Indiana medical profession has come to a consideration of medical service plans after con-

siderable experience has been gained in other states.

These plans, with innumerable variations, fall into two types: 1. Medical Service. 2. Medical Indemnity.

The Michigan Plan is typical of the Medical Service type, and is a non-profit mutual corporation sponsored by the Michigan State Medical Association, and operated, owned, and controlled by medical men, members of the state association.

The plan renders through cooperating doctors

a medical service limited to surgical, obstetrical, and accidental injuries requiring hospitalization and rendered while in a hospital. However, the patient has free choice of physician, but must realize that a doctor who has not agreed to cooperate may charge him more than his benefit.

The beneficiaries are employed people earning not more than \$2,000, single, and \$2,500 per family in any one year. This is the wage class to whom we have always adjusted our fees. Individuals and families earning more than this ceiling are expected to pay the prevailing fees current in the community.

Recent experience in Michigan has led to liberalizing the service by adding twenty-five cents to the policy premium, so that twenty-one days of medical care, if hospitalized, is now being offered. This should be included in our plan. Service has been limited to cases of surgery, obstetrics, and illness of sufficient seriousness to require hospitalization. It has been found that it is because of the catastrophic experience, requiring considerable expenditure of money, that the great majority of people in this wage group need and want help. From the standpoint of control, the insurance carrier does better and operates with greater safety when the risk is limited to the hospital period.

In the report of the Permanent Study Committee on Health Insurance, twenty-one day medical care was contemplated as a part of the Indiana plan, when and if the patient was hospitalized. Twenty-five cents was included in the proposed premium to cover this feature.

Medical Service Plans, as distinguished from indemnity plans, by providing security against additional expense, is believed to be more popular with those in this wage group. If the beneficiary selects a doctor whose services cost more, then the amount paid by the insurance carrier serves to indemnify the beneficiary in the amount ordinarily paid for like service.

This all means that the sick person has complete freedom in selecting the doctor, but if the chosen doctor's fee is in excess of the benefit, the patient must pay the difference.

The Medical Indemnity Plan and the Medical Service Plan are essentially identical, except in the method of paying for the service.

In the Medical Service Plan the doctor receives and accepts as full pay a certain sum for all professional service given in a certain illness, and the insurance carrier sends the check directly to him. In the Indemnity Medical Plan the insurance carrier sends a like sum in a certain illness or diagnosis to the patient to help him pay the doctor.

The Medical Indemnity Plan is aimed at the same social need of the same wage group—the need of protection when sickness comes. The same amount of money will be paid to the beneficiary to pay all or part of his medical expense. If the doctor in the case keeps his fee in line with the earning capacity of his patient, the practical

working out of either plan may be equally satisfactory to the beneficiary. The indemnity plan will require judgment in assessing fees, on the part of the physician, if the working man is to continue to be satisfied. There can be no doubt that in the great majority of cases the relation between patient and doctor will be satisfactory.

Another reason advanced for indemnity as preferable to service plans is that at least from the point of view of medical tradition and policy the benefits of insurance should be paid to the patient, who is then in a position to negotiate with the physician of his choice, and no third party enters the picture. Again, if at some future time government on the state or federal level should take over, the profession will not be committed to a service principle but will have maintained its freedom of action and decision as each case arises. Since a number of states have initiated plans—some having the service type and others adopting the indemnity type, it is quite clear that a decision in Indiana will not determine future government policy, should that moment ever arrive.

The Blue Cross Hospital Plan provides hospital insurance. In this state Hospital Insurance, Inc., is the operating company. The preliminary work of incorporation, writing an acceptable policy form, and organizing an administrative headquarters is completed. Hospital Insurance, Inc., is organized under the insurance laws of Indiana and operates under the supervision of the State Insurance Department—\$25,000.00 capital fund has been raised, and whenever insurance has been sold in an amount to provide \$25,000.00 in prepaid premiums, the corporation will begin active business.

Certain professional services are temporarily included in the Blue Cross Plan. These are x-ray for diagnosis, not to exceed \$15.00, anesthesia, pathology and laboratory service, electrocardiography, and basal metabolism. It is agreed that when a medical plan becomes operative these professional services will be deleted from the hospital plan and included in the medical plan.

Michigan State Medical Service supplies us with the best reliable statistics on its operation. By joining with the Blue Cross and selling both the hospital policy and the medical policy as one complete service, the cost of getting more members has been greatly reduced, since the combined sale costs no more than selling either one alone. If I recall the figures correctly, enrollment costs were only 4 per cent of the premium, administration 7 per cent, and reserves 6 per cent, or a total of only 17 per cent. Viewing this from the beneficiaries' side, 83 per cent of the premium goes into paying medical service under the Michigan Plan. Commercial companies are under much greater expense for enrollment and in adjusting claims so that less of the premium dollar remains available for provision of medical care. Our Indiana Blue Cross is now waiting for our medical plan so that the two may be offered as a complete service.

Our Indiana Medical Plan will have to go through the same process of organization. The \$25,000.00 capital fund will be United States Bonds or other acceptable paper deposited with the Insurance Department. This money can be raised in any one of a number of ways, such as an assessment on the membership, by taking it out of funds of the state association, by certain members of the profession putting up the money or, as I was assured by one layman who should know, that the \$25,000.00 would be advanced by certain philanthropic individuals if the doctors could not do it themselves. As to the \$25,000.00 prepaid premiums, one large concern has offered to supply that the moment we are organized and ready for business. From the foregoing it should be clear that the capital fund and the prepaid premium need be no problem at all.

The size of the premium determines the amount of money that can be paid the beneficiary. It is also true that the amount of premium that working people can afford and are willing to have deducted from their pay for sickness and hospitalization has been fairly determined by experience. The report of The Permanent Study Committee on Health Insurance recommended 95 cents for single individuals, \$1.85 for man and wife, and \$3.25 for families—no limit on size. These combined with the Blue Cross premium will not exceed \$5.00 per month for families, and will be correspondingly less for single persons and couples.

The Reference Committee that received the published report of the Permanent Study Committee

on Health Insurance, taking cognizance of the many factors involved, recommended that the state association organize an Indiana Medical Plan—a mutual non-profit corporation under the insurance laws of Indiana, preferably of the indemnity type; applicable to employed groups of limited wage range; the insurance liability to be restricted to surgical, obstetrical, and medical care while hospitalized. This should be a mutual non-profit corporation organized under the insurance laws of the state. After listening to many good arguments in favor of each of the recognized methods, the committee is quite sure that either plan can be made to succeed under the same able management either plan will require.

The committee voted to submit approval of the Indemnity Plan, the reasons being recapitulated as follows:

1. It maintains medical profession traditional policy of placing or keeping the purchasing power in the hands of the patient.
2. The patient and doctor each retain the fullest independence of judgment and action in respect to the other.
3. It provides an acceptable method for distributing the cost of medical care.
4. It protects the dependents of workers as well as the workers themselves.
5. It provides a plan which together with the Blue Cross Hospital Service can be presented to employee groups as a complete coverage for the catastrophies of illness.

EVOLUTION OF MICHIGAN MEDICAL SERVICE

JAY C. KETCHUM*

DETROIT, MICHIGAN

It is perfectly natural for the doctors of any state or locality to be subject to initial doubts and misgivings when they confront the launching of a prepayment program for medical care, but it now can be said that most of these apprehensions are groundless.

Medical service plans will work. They will work to the eminent satisfaction of profession and public alike. If there is any one set of facts that has been established during the last five years, it is that a professionally-sponsored program of this type is wholly practical, is equally beneficial to doctors and patients, and is eagerly accepted by the public.

I make these statements on the basis of the experience of the Michigan Medical Service, which is here set forth as the case history of an enterprise conceived in uncertainty and subjected to more than

its share of growing pains, but now arrived at a lusty and promising young maturity.

Today Michigan Medical Service has accumulated experience which we sincerely hope will assist other state and county medical societies in embarking upon similar projects with the certainty of sound and orderly development. Michigan Medical Service has enrolled 693,170 subscribers, or one out of every eight persons throughout the state. It has paid some \$8,665,000 for services rendered in 235,000 cases. It is continuing to grow with great rapidity.

It has, in other words, achieved in four and a half years a position that would be considered a resounding success in the business world. But it was not always so. The doctors of Michigan doubted, first, that the people wanted such a program. They wondered if it wouldn't bring in socialized medicine by the back door. They felt, some of them, that medicine should not concern

* Executive Vice-President, Michigan Medical Service.

itself with purely economic questions. They seriously questioned the advisability of a program developed on a service rather than a cash indemnity basis. They were puzzled by the problem of relationships with hospital service plans.

They didn't know, further, what income limits to establish in their plan, or how to ascertain subscriber eligibility, or whether to enforce the limits. They debated the question of complete versus limited coverage. And when it came to determining both charges to subscribers and fees to physicians they necessarily invaded an untrammelled wilderness.

The wonder is that out of this immense perplexity there came anything tangible at all. It is an even greater wonder that the Michigan program managed to survive its beginning years.

In March of 1940, nonetheless, there was introduced the prepayment medical care plan known as "Michigan Medical Service"—a non-profit organization directly sponsored by the Michigan State Medical Society. Standard principles of group insurance were utilized in the program, which proposed to enroll subscribers in groups, each subscriber contributing a certain monthly payment and receiving in return the services of the doctor whenever needed.

The original proposition was to make the new project a "service" rather than a cash indemnity affair. By that it was meant that the subscriber would simply show his membership card to the participating doctor, who had agreed in advance to furnish his services without any direct charge to the subscriber. The physician received a standard fee for each type of service directly from the Michigan Medical Service.

Obviously, the plan was slanted to low-income groups. The income limits for subscribers were established at an annual average of \$2,000 for unmarried persons and \$2,500 for the enrolled family. Michigan Medical Service payments to physicians were based on what was felt to be a fair charge for services to this income class.

But once the Michigan Medical Service sales or "enrollment" representatives entered the field, it was found that the income limits could not be made to stick. The married man who earned \$2,600 represented the fact that he could not join the plan. Employers who were asked to cooperate by making payroll deductions likewise balked, insisting that they had no interest in a program which was not equally available to all their employees.

One of the first major compromises thus resulted early in the history of Michigan Medical Service. It was decided to retain the "full service" provision for employees within the established income limits, but also to permit higher income employees to enroll with the understanding that the participating doctor retained the right to make a charge to the subscriber in addition to the fee he received from Michigan Medical Service. This policy has been

continued to the present, with reasonably satisfactory results.

Meanwhile, Michigan Medical Service quickly found that it had been overly ambitious in endeavoring to provide complete coverage of all the physician's services in the home, his office, or the hospital. For this complete program a schedule of monthly charges to subscribers had been established at \$2.00 for the single subscriber, \$3.50 for husband and wife, and \$4.50 for the full family.

These rates were reached by doubling the average use of the doctor's services and adding a charge for overhead—but they were scarcely half high enough. During the twenty-seven months that the complete medical program was in operation, the monthly income per subscriber averaged about \$1.38, but the monthly cost per subscriber averaged \$2.61, or a loss of \$1.23 per subscriber per month.

Moreover, the public wasn't ready to pay even these "half-cost" charges. The highest enrollment in the complete medical plan was 7,375 subscribers, the average slightly less than 4,000.

Side by side with the complete medical program, however, Michigan Medical Service had been offering limited protection providing only for surgery to subscribers who became bed patients in the hospital. Logic supports this limited protection as the type which would be most urgently desired by the public, since it provides for catastrophic health situations—the surgical cases which most commonly run to heavy expense.

During the same twenty-seven months that the complete medical program reached a maximum of 7,375 subscribers, the surgical plan enrolled more than 350,000 subscribers. But again, rates which had been set too low resulted in financial difficulties. The initial monthly charges for the surgical plan were 40 cents, \$1.20 and \$2.00. Instead of the average of forty operations per thousand persons per year which prevailed for the entire population, the average at one time rose as high as 160 operations per thousand Michigan Medical Service subscribers annually.

For two years and more Michigan Medical Service struggled with a financial situation which threatened its collapse almost at any moment. It took another two years, and two increases in subscriber charges, to achieve the excellent financial position which prevails today.

With the complete medical plan no longer in operation, charges to subscribers for the surgical program now are 60 cents, \$1.60 and \$2.25 per month. A sliding scale increases the charge up to 90 cents monthly for subscribers in groups having a high percentage of female employees. Moreover, Michigan Medical Service insists on enrollment of 75 per cent of the employees of any company, thus insuring a representative group which is unlikely to have a disproportionate share of sickly members in need of surgery.

With the proper sales techniques, there is little difficulty in obtaining this percentage. Actually, it has been necessary to restrain the growth of Michigan Medical Service so that the usual high incidence of surgery in new "unseasoned" groups could be comfortably assimilated. One point which the plan has demonstrated beyond question is that there is public demand for a program of this sort.

Most doctors probably are already familiar with the national polls showing a heavy majority of the population in favor of a federal health insurance program. Proposals such as the Wagner-Murray-Dingell Bill clearly stem from this public demand. Equally clear is the point that some such proposal will inevitably be enacted into law unless the public demand is met in some other way.

That "some other way" has been found in Michigan, according to a factual objective survey just completed by the Michigan Health Council. Whereas the *Fortune* Poll of 1942 showed 75 per cent of the people nationally favoring federal health insurance, and the Gallup Poll of last year showed nearly 60 per cent similarly disposed, the Michigan Health Council survey demonstrated that only 39 per cent of the Michigan population wants "some sort of a government-operated, medical-hospital plan."

The obvious conclusion to be drawn from Michigan's variation from the national sentiment is that the people prefer to have the doctors rather than the government sponsor a prepayment program. This conclusion was further supported in the Michigan study when, after having been asked bluntly and without option whether or not they wanted a federal program, the people were asked what sort of a plan they would prefer if they had a choice.

Given five possible methods of payment for medical service, the Michigan population voted overwhelmingly in favor of a voluntary, professionally-sponsored program. The voluntary, professional plan drew a 33.5 per cent vote, against a mere 15.5 per cent for a government plan. Regular insurance received a 13.4 per cent vote, a union plan a .9 per cent vote, and payment for illness as it arises a 26.6 per cent vote.

This is the answer to the question as to whether doctors should concern themselves with medical economics. They should if they wish to meet the plainly-delineated desires of the public. They *must* if there is not to be compulsory federal medicine.

I believe that the not uncommon feeling that such a plan as Michigan Medical Service provides back-door entry to "socialized medicine" is dissipated by a little thought about the nature of the plan. All the plan does is to enroll members, collect their payments, and pay the physicians.

It does nothing to interfere with the doctor-patient relationship. It exercises no control over doc-

tors, for even the doctor's participating agreement is a contract with the subscribers rather than with the plan itself. Nor does Michigan Medical Service have anything to do with setting the fees paid for medical services. These fees are determined by committees of the doctors themselves. Finally, the plan is under the doctor's control in any event, for it is their own program and is operated as they want it to be operated.

From the start it was the feeling of the medical men who led in the establishment of Michigan Medical Service that the program would be as beneficial to the profession as to the public. Four and a half years of operation have borne out this belief. For that portion of his fees which is the obligation of the plan, the doctor has no uncollected or uncollectable items. On the average, he is paid within two weeks after his statement reaches the plan. He need not delay needed surgery for plan subscribers because they are hard-pressed for money. Even if he is a general practitioner rather than a surgeon, he usually shares in the plan's payments. Sixty-five per cent of the money paid out by Michigan Medical Service, which at present is exclusively a surgical program, goes to the general practitioners of the state.

So far as the public of Michigan is concerned, the surgical care plan of Michigan Medical Service and the Blue Cross hospital care plan of the Michigan Hospital Service are "one package." Internally, Michigan Medical Service and Michigan Hospital Service are separate corporations, dealing with their respective professions. But the subscriber is enrolled in both programs simultaneously; he makes a single payment which is then apportioned between the two plans; he has a single membership card which he shows to both the doctor and the hospital when he needs service.

It is almost mandatory to present this unified front to the public if the plans are to succeed. Neither employers nor employees will be bothered with signing and paying for two separate services in what they consider to be the same field. It is equally desirable from the plan economy standpoint to eliminate excessive duplication by maintaining a joint record system.

It is one of the fine traditions of medicine to examine every new technique or procedure microscopically, to begin by "tearing it apart" in search of flaws. In medicine, imperfections are likely to result in widespread catastrophe. Michigan Medical Service has been subjected as fully as any new medical technique to this type of critical searching analysis on the part of medical men throughout the state. But medical tradition also embraces the most rapid utilization of new procedures once they have been proved. It is naturally our feeling that the prepayment procedure utilized by Michigan Medical Service and its companion medical service plans now has been proved beyond any reasonable doubt.

VOLUNTARY MEDICAL SERVICE PLANS IN NEW JERSEY — A REPORT TO THE PHYSICIANS OF INDIANA

NORMAN M. SCOTT, M.D.*

NEWARK, NEW JERSEY

With only a few days' advance notice, we are submitting this report on our experience with voluntary medical service plans in New Jersey, as requested by your editor. We would like to have it considered as a report to the physicians of Indiana. Our report is largely factual in character, rather than academic.

If adequate medical care is to be made more available to all persons, we must recognize two economic groups: 1, the group of indigent and medically-indigent persons; and 2, the group of self-supporting persons. We must concede that the problem of the indigent and medically indigent is a joint responsibility of the government and the medical profession, and that the problem of the self-supporting group is a responsibility of the individual, who must, in accordance with the traditional principles of democracy, provide for his own welfare and the welfare of his dependents. The problem in most areas does not involve adequacy of personnel or facilities. It is an economic problem, and to find a solution we must break down the economic barrier which frequently exists between the profession and persons in need of medical care.

The solution must be determined by evolution, based upon experiment and experience. Our program must be evolved within the present framework of medical practice—provide for free choice of physician and patient; free enterprise, personal initiative and dignity of the profession and the individual physician; maintain high standards of medical care, and provide an adequate income to the profession.

To evolve such a program, The Medical Society of New Jersey, under the provisions of a special enabling act, organized two non-profit medical service corporations. The corporations operate under policies approved by the Medical Society of New Jersey; all activities are first approved by the society, and all members of their boards of trustees are nominated by the Society.

Medical Service Administration of New Jersey was incorporated in 1940. It studies the medical problem of the indigent and medically indigent, and evolves plans for a solution of their problem. At present it operates two plans, as follows:

1. Farm Security Administration Medical Plan. This plan, as operated in New Jersey and in other states, is sponsored by the Federal Department of Agriculture for the benefit of low-income farmers who have been loaned money by the Federal Government for purposes of rehabilitation. In New Jersey

the plan is limited to payment for home and office care, and has been in operation three years. The subscription rate of this plan varies, from \$16.00 annually for single subscribers, to \$24.00 annually per family according to the number of dependents. The income from the plan is equal to \$4,600.00 per thousand persons annually. This we do not consider as an adequate income to the profession, but it does prevent a certain loss of income to the profession; provides an income greater than would otherwise be obtained from this economic group; and provides, in a limited way, for the needs of these persons. The plan is designed to pay \$1.50 for office calls and \$2.50 for house calls. On three occasions during the past year it was necessary to reduce our payments for the month by 25 per cent. There is a high sick rate in this group. There are many defects and deformities. The group needs a program providing for costs of hospitalization and medical-surgical care rendered in a hospital. Such a program would cost \$65.00 to \$70.00 per year per family, which is beyond their ability to pay. We are continuing the plan in its present form because it does assist in the solution of the problem, and is evidence that the profession is willing to cooperate with the government where the need is shown.

2. The City of Newark Medical Plan. This is for the benefit of the indigent and medically indigent of the City of Newark who are confined to their homes because of illness. It does not include office care, which is adequately provided for by existing city facilities. The indigent are those whose names appear on the welfare rolls of the city. The medically indigent are those determined as being medically indigent by the Newark Board of Health. Free choice of physician is provided. Physicians submit their bills directly to Medical Service Administration. The administration pays the physicians and is reimbursed by the city. The plan has worked very well, to the complete satisfaction of the city, patients, and physicians. Physicians' fees are \$2.00 per day call, and \$3.00 per call after 8:00 P.M.

Medical-Surgical Plan of New Jersey is the second corporation organized by the Society. It is designed for the benefit of self-supporting, employed persons admitted to hospitals for treatment. It provides benefits toward the cost of medical, surgical, and obstetrical services rendered in a hospital, including consultations, anesthesia, and surgical assistant. The monthly subscription rate is 75 cents per individual subscriber, and \$2.00 per family, including eligible dependents.

The plan has been in operation two years. We consider this plan, and our entire program, as ex-

* Executive vice-president, Medical-Surgical Plan of New Jersey.

perimental and evolutionary. About 2,900 participating physicians have agreed to deem as payment in full the amounts paid by the plan for services rendered patients admitted for semi-private or ward hospital accommodations.

Hospital Service Plan of New Jersey cooperates with us as follows: Our contracts are sold through the facilities of their enrollment department. They do our billing, collecting, and general accounting. Statistical work is available through their statistical department and business machines. Each of our subscribers is also a subscriber to their plan. Hospital Service Plan notifies us each time any person enrolled in our plan is admitted to a hospital. For these services we are currently paying 12 per cent of subscription income each month. It is only with such assistance from an organization experienced in a similar field of insurance that a voluntary medical service plan can be successful in its early stages without the aid of a large capital fund. Medical-Surgical Plan maintains a separate office through which are handled all matters relating to medical care standards, relationship with physicians, and problems referred to the plan concerning relationship between physician and patient. We handle our own claims, and all disbursements for operating expenses and fees to physicians.

Our contracts average 2.2 persons, providing a monthly income of 67 cents per person. The income per person has remained constant and is applicable to New Jersey, where the average family consists of 3.8 persons, as buffered in the plan by an enrollment consisting of 42 per cent single persons. Income per person is the most important and basic economic unit in any plan which enrolls all families at the same subscription rate, regardless of the number of enrolled family dependents.

The second and most important factor is the percentage of enrollment obtained in each group. The higher the percentage of enrollment, the more favorable is the cross section of health in the group, and the better the claim experience. For instance, groups with a 30 per cent enrollment have to date cost us 67 per cent of earned income for claims, and groups with 75-100 per cent enrollment have cost us only 44 per cent of income for claims.

There is a progressive increase in claim costs and hospital admission rates as the plan assumes responsibility for obstetrical and maternity care. Claim costs are higher in summer than in winter because of increased frequency of tonsillectomy and elective gynecological operations during the school vacation period. During the first six months of 1943, our claim costs were 53 per cent of income, with an admission rate of 58 per 1,000 annually. During a similar period in 1944, our claims cost 69.7 per cent of income, with an admission rate of 86. In July, 1944, claims cost 75 per cent, with an admission rate of 104; and in August claims cost 80 per cent, with an admission rate of 113; while in September, 1944, following the school vacation

period, our claim costs dropped to 60.8 per cent of income.

The normal hospital admission rate in New Jersey is 77 per 1,000 per year. The difference between our rate and the state rate is due to two factors: 1, low percentage of enrollment with resulting adverse selection of health risk in many groups, and correctable only if we obtain 100 per cent enrollment; and 2, the fact that many persons enrolled in the plan would not otherwise have entered a hospital for treatment because of the costs.

Medical-Surgical Plan has paid all operating costs and claims from its earned income and accumulated modest reserves. Operating costs during the first six months equalled 51.3 per cent of earned income. As enrollment and income increases, this percentage cost decreases. In August, 1944, our operating costs were 16.9 per cent of income, of which 12 per cent was paid to the Hospital Service Plan and 4.9 per cent incurred in this office.

No presentation would be complete without a discussion of physicians' fees and income to the profession. A new plan cannot guarantee specific or fixed fees per service. The fee for service paid the individual physician will depend upon the relationship between the income to the plan and the size of the clinical load to be paid for. We can estimate rather accurately the income to the profession as a whole, and the rate of annual income per individual physician, as follows: Assuming that the population of New Jersey was enrolled (4,200,000) and that the 4,500 doctors in private practice in New Jersey were participating, as would be under a Wagner Bill Plan,

Population	Monthly Income per Person	Monthly Income to Plan	Per Physician per Month	Per Physician per Year
4,000,000	× .67	= \$2,680,000	÷ 4,500	= \$595.00 = \$7,140.00

This would be the income (less operating costs) for services rendered in the hospital, as compared to the estimate under the Wagner Bill Plan of \$5,000 a year per physician for home, office, and hospital care.

Payment for medical care in addition to surgical and obstetrical care is an entirely new field of effort. We feel that it is necessary to include medical care if a high standard of care is to be maintained and if the needs of our subscribers are to be provided. The admission rate for medical cases is higher in winter, reaching 21.5 in March, 1944, which cost in claims 16 per cent of the income for that month. In June the medical admission rate had fallen to 10.7 and the claim cost was 6.2 per cent of the monthly income. The average cost per medical case has been \$37.77, with no appreciable difference during winter or summer.

The fees paid are exemplified as follows: for medical cases, initial hospital visit \$5.00, subsequent daily hospital visit \$3.00; for surgical cases, appendectomy \$100.00, tonsillectomy \$40.00, complete hysterectomy \$150.00, consultations (medical or

surgical) \$10.00, other fees being consistent with these examples.

This brief summary covers a two-year experience in which our enrollment has reached 28,000 persons.

The cooperation of physicians has on the whole been very satisfactory. There is a growing realization among the profession that such voluntary plans are necessary, but we have the usual number of skeptics and cynics who are not willing to participate. Two county societies of important industrial counties do not approve of the plan, and we do not operate in their counties. Our most difficult problem is to gain the united support of the profession in these plans. It must be accomplished if the plans are to be completely successful.

The main objection by the profession is based upon the provision for complete service, at fees payable by the plan, to those persons admitted to hospital for semi-private accommodations. There has been some abuse of this provision. Fifteen per cent of the patients have used private rooms, in which cases our payments are considered as indemnity payments against the physician's bill. Fifteen per cent parallels the reported percentage

of families in New Jersey with incomes above \$3,000 per year during normal economic periods. To correct this alleged defect, it was necessary to amend our enabling act. This was accomplished during the last session of the state legislature, and beginning on November first we will issue a new contract providing for complete payment for service to subscribers under a single contract with annual incomes below \$2,000, and family subscribers with incomes below \$2,000 plus \$500 for first dependent and \$250 for each additional enrolled dependent.

Our experience has been successful, in that we accomplished what we set out to do. We have paid all operating expenses and paid all claims in accordance with pre-determined estimates. Like any new venture, it has not been perfect and defects must be corrected as indicated by experience.

Our conclusion following a two-year experience is that the problem of the self-supporting, employed person can be solved on a voluntary basis, providing the medical profession and the people want to solve it on the basis outlined in this report.

31 CLINTON STREET,
NEWARK 2, NEW JERSEY.

CALIFORNIA PHYSICIANS' SERVICE

A. E. LARSEN, M.D.*

SAN FRANCISCO, CALIFORNIA

In February of 1939, after many years of study, discussion and debate, the medical profession of California created the California Physicians' Service as its agency to explore, on a broad practical scale, the field of furnishing medical care with "free choice of physician" through the use of pooled funds prepaid by beneficiaries. Through formal action, the House of Delegates of the California Medical Association set up a non-profit corporation, controlled by the medical profession through the votes of the participating physicians. Special enabling legislation was secured, so that incorporation under existing insurance laws could be avoided, in order that this state-wide corporation might remain a true service organization in all respects. After much debate California chose the service principle instead of indemnity. It was the belief of the majority that service must be basic if the plan was to serve any public good.

Management of the California Physicians' Service is vested in a board of trustees. The membership on the board may consist of either doctors of medicine or lay persons, elected by the vote of the House of Delegates. The trustees employ and direct the administrative staff and set the policies

under which the benefits of the plan are offered to the public.

As a pioneer effort without the aid of any other organization's previous experience, the California Physicians' Service has encountered many difficulties in developing a practical and simple plan of operation. The first offering was a comprehensive medical service plan, which was later converted into a more limited coverage. Although growth has been slow, the California Physicians' Service has now reached a total membership of over 100,000 persons, producing an income of well over \$1,500,000 a year. The bulk of this membership is enrolled under the standard California Physicians' Service plan, which provides surgical care for the entire family, with additional medical care, except for the first two visits, available to the subscriber or head of the family. The remainder are enrolled under a special Rural Health Program, operated in cooperation with the Farm Security Administration, for low-income farm families; and in the War Housing Program, operated in cooperation with the Federal Public Housing Authority, for the residents of certain congested areas of the state.

Throughout all of its history, the California Physicians' Service has followed the policy of attempting to produce a high quality of medical service and to maintain the simplest possible relationship between the doctor and his patient by eliminating the

* Executive medical director, California Physicians' Service.

traditional insurance contract exclusions and limitations that could be removed with reasonable financial safety. It has attempted to adapt itself to the existing pattern of medicine as it is practiced in this state, and to do this with as little evidence of injecting a third party between the doctor and patient as possible. Part of this has been accomplished by refinements in the contracts from time to time. For instance, a disturbing clause traditionally included in commercial insurance contracts, and some plans, has been the exclusion of pre-existing conditions. Whenever a case of this kind appeared for decision it immediately made the attending physician a claims adjuster, subject to all the criticisms and misunderstandings that adverse settlement would produce.

California Physicians' Service policy has been to remove as many of these irksome practices as possible, so that there is as little change for the prospective patient as possible. This produces good public relations, which is of value to the profession in the long pull. The removal of these exclusions and limitations naturally affects financial balance, but was undertaken on the premise that good medical care is worth its cost, and that a quality offering can be sold to the public even at higher prices; and that further, if the membership dues necessary to support such a program are actually beyond the means of some of the low income groups, then funds to supplement the financial ability of these low income groups should come from other sources—perhaps the employer, or even the public.

In order to make possible an experiment based upon this premise during the last five years, the participating physicians of California Physicians' Service have consistently delivered their best efforts and have accepted a unit basis of compensation therefor which has been less than the projected par value of the fee schedule. Although the actual reduction of fees to any particular physician has not been great because of the relatively small enrollment, nevertheless, in the aggregate the contribution of the medical profession throughout these five years has been considerable.

One of the greatest problems has been to find satisfactory means of informing the medical profession regarding the activities of the plan, particularly those which resulted in reduced fees to the doctors. No plans such as this can hope to

succeed unless it has the understanding support of the rank and file of the medical profession, and if California Physicians' Service experience is to serve as a guide to any other professionally-sponsored plan, the matter of keeping the medical profession interested and informed at all times is of vital importance.

Currently, California Physicians' Service is operating on a reasonably sound financial balance between the rates paid by the beneficiaries and the compensation to the physicians. From past experience, however, it is indicated that this condition is not completely static. A number of factors which are present now may either disappear or assume entirely different significance in the future. Employment conditions in California are far from normal because of the many war plants in operation here, and the period of reconversion may have serious impacts upon the continuing financial solvency of the plan. Many of the members of the California medical profession are in the armed services, and there has been a considerable over-all population increase. Doctors' offices are crowded now, and there is a possibility that certain of the frills of medicine are not available to the public. It may be that plans limited to surgical care will not be greatly affected by the post-war return to normal conditions, but plans offering medical care may find considerable change.

In any case, it is not safe to think in terms of having arrived at any particular goal. Planning for the future must be constant, and in terms of more and more people and better and better care. It is only by such means that the medical profession may demonstrate that there is no necessity for direct intrusion of any governmental agency. California Physicians' Service has well demonstrated its ability to deal directly with groups of employed persons on a voluntary basis, and also its ability to take care of any special problems with special groups where there is a public responsibility.

With the experience gained by California Physicians' Service and other established plans with rates, benefits, sales techniques, there would seem to be no necessity for other states to go through a similar period of gestation. A plan to fit and suit particular needs—and these will vary from state to state—could be worked out with reasonable assurance of success from the very outset.

State membership dues for 1945 will be fifteen dollars, which includes a five-dollar special war emergency assessment. For detailed discussion, see House of Delegates' minutes on page 660.

AN EIGHT-POINT PLAN OF "BOOT TRAINING" FOR THE HOME GUARD OF AMERICAN MEDICINE*

(A Message from the Councilor of the Third Councilor District of the
Indiana State Medical Association)

AUGUSTUS P. HAUSS, M.D.

NEW ALBANY

Since Pearl Harbor, and since the last meeting of the Third District Medical Society, many changes have taken place, many problems have come up, and many issues of vital importance to public welfare and the medical profession await decision.

During the past year your councilor has had to face many of these changes, problems, and issues in an humble effort to carry on the work of his distinguished predecessor, Lieutenant Colonel William H. Garner, now in the armed forces. He wishes to take this opportunity to express his appreciation to those representatives of the Third District and the House of Delegates who chose him to occupy the place of Doctor Garner.

In presenting this report today on the state of the district society, I wish to divide the activities into three fronts, namely, the organization front, the war front, and the home front. I am going to speak frankly because I am in earnest. I am going to throw a few brickbats along with the bouquets.

On the "organization front" I find many brickbats to throw, but they will be aimed at no particular person and are thrown to help and not to hurt. By the organization front I mean the activity and interest of you as individual physicians in your county, district, and state medical societies. During the past year it has been my lot and privilege to serve on three state committees and the state council. I have made no less than ten trips to Indianapolis. At several of these meetings there were supposed to be representatives of every county society, and I came away discouraged because there were only one or two, or none, from the Third District. This year at the annual Secretaries' Conference, which was probably the biggest and most important meeting of its kind held in years, I was downright humiliated when I called for a Third District Conference after the morning session and found that there were only two representatives there.

Recently I attended the important legislative conference at Indianapolis. The legislative committee of each county was supposed to be there with the answers to an important legislative questionnaire. Dubois County was the only county in the Third District that was personally represented, and only two of our counties answered their questionnaires.

During the past year I have called by phone or personally consulted an officer in each county society. I find that all society meetings are poorly

attended. In some counties there are not enough men left to hold a meeting. Members of another county told me they "just adjourned for the duration." Brother, things happen during the duration! These conditions are, of course, partly due to the scarcity of physicians, but if there is only one man left in a county it is more than ever his duty to protect American Medicine until our colleagues in the armed forces come marching home.

I have thrown these brickbats into the field because I sincerely feel that the Third District is falling down on the organization front. I frankly confess that I do not know the answers. I could at this moment go into an hour's tirade on the lack of a national policy and aggressive leadership in the American Medical Association, but that would only be my insignificant opinion, and I believe it is only fitting and proper for us to first place our own house in order before we criticize those in higher places.

I must admit that the more I study the future of American Medicine, the more confused I become, and the less I am able to interpret the wishes of my colleagues in my county, district, and state. I have heard doctors in this district raise a veritable hullabaloo because the State Board of Health was encroaching on their private practice by vaccinating the poor children in the public schools, and I have seen these same doctors send all their prenatal and premarital blood tests and other laboratory specimens to the state laboratory instead of patronizing their own local hospital or their colleagues in one of the fifty some odd approved ethical private laboratories in the state.

I have seen doctors in this district vigorously oppose federal or state aid toward enlargement or needed improvements of local hospital facilities, yet at the same time they teach their wealthiest patients State Medicine by sending them to a state hospital for free x-ray and special diagnosis instead of sending them to a roentgenologist or diagnostician in private practice, little realizing that each time they send a laboratory specimen or a patient who is not indigent to a state laboratory or institution they are placing an unfair burden on the taxpayers; falsifying a statement that is contrary to medical ethics and detrimental to the interest and income of their own colleagues in private practice; and last, but not least, issuing in black and white documentary evidence favoring State Medicine.

I sat in the House of Delegates and in the annual Secretaries' Conference and heard a great furor

* Presented at the Third Councilor District Meeting, held at New Albany on September 20, 1944.

of objection to the Federal Government fostering State Medicine upon us by paying the doctors direct for the obstetrical care to servicemen's wives, and then I heard some of these same doctors later demand that the county welfare departments take away from the aged indigent their last semblance of self-respect by refusing them the privilege of paying their own doctor bills.

I heard a very important state committee, headed by a learned and highly-respected past president of our state association, present to the House of Delegates a report on a subject upon which they had devoted months of sincere study and investigation. Not less than a dozen amendments and objections immediately shot up from the floor, and before the report could be adopted there were so many controversial remarks made that it sounded like the Tower of Babel.

Is there any wonder that I confess I am confused and do not know the answers? Is there any wonder that I have seen our distinguished past president and very efficient presiding officer, Doctor McCaskey, at times stand aghast and dismayed? Is there any wonder that I have seen Tom Hendricks drop his head and shake his shaggy mane, as if to say, "What the hell next?" Is there any wonder that President Oliphant's shoulders are stooped from carrying the burden of organized medicine in the most trying year in the history of the state?

Confused and bewildered as I am, I do know that the enemy is at our gates and that we are unprepared. We must have the enlistment of every medical man on our organization front, and as your councilor I respectfully submit the following eight-point plan of "boot training" to make you a good soldier in the Home Guard of American Medicine:

1. Read your State Journal and thereby become familiar with what is going on.
2. Hold and attend regular monthly county society meetings.
3. Elect secretaries who will attend state conferences, follow directives, and reply to inquiries of the state and national association.
4. Plan an attendance campaign for your county meetings.
5. Appoint aggressive and militant committees on legislation and other organization subjects.
6. See that your county society is represented at every state or district conference when requested.
7. Have more discussion of current state and national medical trends and issues at your county meetings.
8. Plan to attend your state meeting annually.

Your district chairman, your state president, or your county secretary cannot do all these things for you. Let us each and everyone take this "boot training," choose our leaders wisely, and not become stampeded by a lot of prattle about the high cost of medical care, when common bricklayers are receiving twenty dollars a day—men whose only training was a short apprenticeship at good pay,

whose only investment is a trowel and a pair of overalls, and whose only diploma is a union card. You are definitely worthy of your hire, so let us get back in the middle of the road and stand shoulder to shoulder with our professional brothers instead of being scattered like a flock of frightened sheep.

Your councilor is happy to report that the physicians of the Third District of Indiana have not fallen down on the war front. Serving first on the Selective Service Board and then on the District Appeal Board, he has been able to personally observe the work of his medical colleagues in the district, and has the word of the state Selective Service headquarters that you physicians of the Third District have done a splendid job and are second to none in the state.

Your councilor has been in close touch with the State War Participation Committee in the work on Procurement and Assignment of Physicians for the armed forces, and on a few occasions has been assigned on special investigations. He is pleased to report that the Third District has not been found wanting in patriotism. You should be proud of the following official records: There were fifty-five physicians in the district under the fifty-five-year age limit for military service. Forty-eight of these voluntarily enlisted, ten of whom were rejected because of physical disability. Four others are definitely known to be physically disqualified. No district can point to a better record on the war front.

Your councilor, at the request of the state association, accompanied Colonel Merriweather, of the United States Public Health Service, on a complete medical survey of Floyd and Clark counties, and, in addition, has interviewed physicians and private citizens in every county in the district. This was done for the purpose of determining the adequacy of medical care in the district. He wishes to bring to your attention several points resulting from these surveys:

1. There was a definite attempt by the United States Public Health Service to interfere with the private practice of medicine in Clark County by having the medical staffs of the large war-plants treat the families of their employees. This was vigorously opposed by your representative and not approved by the war plants or their medical staffs.
2. An opportunity to improve and enlarge the hospital facilities in Floyd and Clark counties was lost by lack of aggressiveness of the county medical societies.
3. There has been a scarcity of physicians in every county, but no community has actually suffered from lack of medical care.

He found that it is the doctors and not the patients who are "taking it on the chin." He found unsung heroes on the home front well in their sixties now working eighteen hours a day, who traveled the same roads with horse and saddlebags forty years ago; surgeons past three score and ten, with trembling hand but steady scalpel, performing

major operations and bringing their patients back alive; brilliant young physicians and surgeons, disciples of modern medicine, already physically handicapped and disqualified for military service, deliberately shortening their limited span of life by overwork; country doctors, the noblest of the profession, "most wise of all that wisest be, most true of all that's true, say we," some past ninety years of age, too feeble to drive a horse, too frail to steer a car, but still visiting the humblest homes along the roughest roads, delivering babies into a world from whence they themselves are about to leave.

Yes, no one can say that the physicians of the Third District have fallen down on the home front, and this report would not be complete without paying a sincere tribute to the wives of our doctors for their sacrifices and services, and to the active

work of our state Woman's Auxiliary, under the splendid leadership of our own beloved state president, Mrs. James Baxter, Jr., of New Albany.

We who have been privileged to remain at home must say to those of our colleagues who are now in the armed forces:

"We honor your valor and recognize the sacrifices you have made. State medicine shall not rob you of the private practice you left behind. We look forward to your home-coming. We pledge you a sincere welcome, and there will be a place for you in this community to practice medicine in the American way.

"We believe that you will find a public more considerate and more appreciative of American Medicine as a result of the sacrifices you have made on the war front and the services of your colleagues on the home front."

POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of November, 1919.)

Three papers were presented in the scientific section: E. B. Mumford, of Indianapolis, discussed "Active Mobilization of Joint Conditions"; John A. MacDonald, of Indianapolis, discussed "Meningococcus Cerebrospinal Meningitis"; and Scott Edwards, of Indianapolis, discussed "Blood Sugar Tolerance in Cancer."

* * *

Editorially, there were several discussions, chief of which was a typical Bulson tirade, this time his spleen having been vented in the matter of "Superheroes," referring to too many dinners, et cetera, having been given for returning physicians, at which events all too often the recipient of the honor was made out to be a real hero.

* * *

Federal Health Insurance was being rather strongly urged in many sections of the country.

* * *

A start was made on the building of the new nurses' home at the Indianapolis Methodist Hospital; the estimated cost was to be \$300,000.

* * *

It appears that several members of the state association had not yet paid their dues for the current year, and a drive was on to bring the recalcitrants into line.

* * *

Letters already were being received from Germany by American physicians, urging them to buy German products, such as medical books and surgical instruments.

* * *

Some of the private laboratories were accused of soliciting work directly from the laity, and of making laboratory reports directly to private individuals.

Adams County physicians had started a campaign for a county hospital in that community.

* * *

The Clay County Medical Society had made out a "dead beat" list of local residents, and had solemnly vowed and declared that they no longer would care for the ills of these folks unless they "paid up."

* * *

The Michigan law, then recently enacted, regarding the division of medical and surgical fees was also discussed.

* * *

The urgent need of reporting venereal diseases, the matter of post-surgical risks, medical society slackers and social and industrial unrest also came in for their discussion.

* * *

The annual convention of the Indiana State Medical Association, held in Indianapolis a month earlier, is reported to have had the largest attendance in the history of the association; more than seven hundred physicians registered for the gathering.

* * *

Dr. William Lowe Bryan, then president of Indiana University, had been named state head of a committee to take over the sale of what we now call "Christmas Seals." It was announced that the goal set by the committee was \$270,000.

* * *

Indiana physicians returning from the armed services were: E. B. Chenoweth, Seymour; R. G. Markle, Huntington; W. W. Wright, Newcastle; C. R. Sowder, Indianapolis; H. S. Thurston, Indianapolis; Karl T. Brown, Muncie.

"THE FIELDER" VISITS THE DOCTORS*

S/SGT. WILLIAM F. KILEY

Base Public Relations Office, Stout Field,

INDIANAPOLIS

The sky was as gloomy as a GI reporting back from a fifteen-day furlough. Ceiling was zero-minus-ten during the morning, but around two o'clock in the afternoon the clouds were dispelled and the sun shone through. It smiled a greeting on more than one hundred doctors who were guests of Stout Field for a glider and air evacuation demonstration.

The doctors were members of the Indiana State Medical Association, which had been holding its annual meeting in Indianapolis, and the visit to Stout Field was the climax of the five-day session. With the doctors came their wives, and we suppose there were also some lady physicians present.

The sun remained out for exactly one hour. At three o'clock the skies clouded again, and a curtain of rain was drawn on the demonstration. This, then, is the story of that one hour:

The assignment to cover the visit of the doctors was received with glee in the Base Public Relations Office. Some of the younger members of the staff remembered doctors from their civilian days, but after reading letters from home they had come to believe that there weren't any doctors outside of the Army any more. We figured it would be quite a treat to see so many doctors in civilian clothes, and especially doctors we didn't have to salute or stick our tongues out for.

At the north side of the field, south of the Chemical Warfare Building, a C-47 air evacuation plane was parked, as well as an L-5 ambulance plane. A roped area confined the medics to a safe section of operations in order to prevent anyone backing into whirling propellers and becoming a patient of one of their own fraternity. The setting was ready.

At two o'clock Sgt. Herbert Segerman stepped to the microphone, which had been rigged up by the Base Signal Section, and into it spoke carefully accented words, thus:

"Members of the Indiana State Medical Association and guests—welcome! You are now at Stout Field, headquarters of the I Troop Carrier Command. The plane which you see before you is a C-47 air evacuation plane, exactly like those which flew more than 175,000 wounded soldiers out of combat areas during 1943. On the field you see other Troop Carrier Command planes and gliders, the same planes and gliders which spearheaded the attack in North Africa, the Southwest Pacific, Sicily, Salerno, Normandy, Southern France, and, more recently, in Holland. We are glad that you have come to visit us this afternoon. We think the things we have to show you will interest you—as medical men—and as Americans."

With that introduction the microphone was turned over to Major Greenberg, who had accompanied the air evacuation unit from Bowman Field, Kentucky. Major Greenberg then described

* Reprinted from *The Fielder*, Stout Field, Indianapolis.



Interested spectators watch Air Evacuation Demonstration given at Stout Field.

the process used in evacuation of the wounded. With the air evacuation plane was a full complement of corpsmen, including a flight nurse. Twenty-one stretchers, complete with blankets, had been laid out on the ground. The call for volunteers found twenty-one doctors eagerly jumping over the ropes to take their places on the stretchers. You'd think the doctors hadn't had a chance to lie down in years.

That was the signal for Sam Katz to go to work. A visiting oculist took a quick look at Sam's eyes, and pronounced them in focus. The sergeant was then given permission to use flash bulbs and film to record photographically the happenings of the afternoon.

As the process of air evacuation was explained by Major Greenberg, medical corpsmen carried the doctors—who were enjoying being patients—into the C-47 and lashed them safely away. Each step of the process was explained by Major Greenberg on the public address system. In short order all twenty-one of them were tucked away in their litters. The crowd was then invited to step forward to go through the plane. They complied eagerly, and it is presumed that they learned a lesson of medicine in wartime which they will remember.

Members of the Stout Field military turned out en masse to welcome the doctors. Present were Brigadier General William D. Old, Colonel Robert J. Benford, and practically every doctor in uniform on the base. Lieutenant Colonel D. A. Pfaff was busy shaking hands with old friends, while Major C. J. Kvidera, Major W. T. Zimmerman, and others of the medical staff watched the proceedings.

During intermission in proceedings on the ground, the air hummed with activity. Captain Eugene Jett, at the controls of a C-47, pulled gliders through the air. As the glider pilot cut loose from the tow plane, Sergeant Segerman kept up a run-

ning description of the action over the microphone. He explained the tactical advantages of the glider, a surprise attack, and the delivery of fighting units intact on the ground. He told how each tow rope consisted of 325 feet of nylon strands, enough for 1,620 pairs of nylon stockings. The women sighed when they heard that remark.

Gliders soared gracefully through the air, then came in for a silent landing near the crowd. Then came the real thrill of the afternoon—the doctors and guests saw two snatch glider pick-ups.

Down came the C-47, sailing with unerring accuracy for the tow rope suspended over the up-rights to one side of the landing strip. A thrill rippled through the crowd as the glider was airborne—swiftly following the flight of the tow plane. Twice the plane came in and both times the tow rope was caught firmly in the hook. It was undoubtedly the highlight of the demonstration.

A glider was pulled into position near the crowd. As the nose was being lifted, one of the guide wires stuck, and it looked for a minute as if the two soldiers were not going to be able to lift the nose. In a moment they had help. General Old was there putting a hand to the nose—holding it in place—while rain dripped down his coat sleeve. In a few seconds the general and the soldiers had help, and the nose went all the way up. The doctors went in and out, noting everything—asking questions which were cheerfully answered.

As if timed by the weather section, the rain began to pelt down to signal the end of the demonstration. The doctors invited cardiac dilatation as they sprinted for their cars. All of them made it without being sprinkled any more than the laundress sprinkles a shirt before ironing. We think they had a good time; we enjoyed showing them the I Troop Carrier Command and Stout Field; we hope that they come back.



The twenty-one doctors who scrambled to become heroes at the Air Evacuation Demonstration.



"The shoe is on the other foot," says "The Fielder" as a doctor is loaded by medical corpsmen into the cargo door of an Air Evacuation plane.

(Photos by Sgt. Sam Katz.)



Military News



Captain Ralph D. Arnold, of Ligonier, has left his former station at Fort Sill, Oklahoma, for a New York APO address.

A V-mail change-of-address form indicates that Major Glenn E. Comstock, of Gary, is in Belgium with an engineering group.

Lieutenant Colonel Melvin S. Durkee, of Evansville, has left Camp Grant, Illinois, for an overseas destination, as evidenced by his New York APO address.

In a recent letter Captain Elmer A. Barron, of LaPorte, expresses appreciation for the "MedSoc" letters and *THE JOURNAL*, and gives a new address. Captain Barron is in the Dutch East Indies.

In a letter to *THE JOURNAL*, Major Joseph C. Dusard, of Bedford, states, "I have been in England for some time now. This is a tented hospital, placed in a beautiful wooded area. We have a very nice group and are being kept fairly busy."

Dr. Herbert L. Cormican, of Elkhart, was ordered to report to Carlisle Barracks, Pennsylvania, on October sixth for initial training in the Army Medical Corps. Doctor Cormican has been commissioned a first lieutenant, and after completion of the course at Carlisle will be assigned to duty at the LaGarde General Hospital, in New Orleans.

Captain Elizabeth L. Bryan, one of the fifty-five women physicians in the Army Medical Corps, has been assigned to Wakeman General Hospital, Camp Atterbury, as a psychiatrist. She previously had been stationed at Camp Blanding, Florida, where she had been assigned after a period of psychiatric training at the Lawson General Hospital, Atlanta, Georgia. Prior to her entrance into the Army, Captain Bryan had had considerable experience in a psychiatric hospital in the East.

Captain George Colip, of South Bend, writes that his unit has been converted into a mobile type hospital, and that they have had a very active part in the invasion of France. "We are doing lots of work, both medical and surgical. The volume is tremendous. Wish I could quote the figures. I am tired of surgery. Twelve to eighteen hours a day of one case right after the other gets to be old stuff after a while. I saw Captain George Gates the other day. He was in good shape at the time."

Captain Marion H. Morris, of Indianapolis, has been transferred from Randolph Field, Texas, to Mitchell Field, New York.

Captain E. B. Boyer, of Indianapolis, has been transferred from Camp Campbell, Kentucky, to Camp Beale, California.

Formerly at Columbus, Ohio, Captain Franklin F. Premuda, of East Chicago, has been transferred to Palmer Field, Bennettsville, South Carolina.

Captain Joseph B. Quigley, of Indianapolis, is now on duty with the station hospital at Chanute Field, Illinois. Formerly he was at Mitchel Field, New York.

Lieutenant John K. Jackson, of Aurora, states in a V-mail letter: "I recently received my July *JOURNAL*, and read where I was in a new station at Camp Lejeune, North Carolina. Since then I have put thousands of miles behind me, and am on an island in the Pacific." Lieutenant Jackson is on duty with the Navy.

Lieutenant John A. Hetherington now is stationed at the general hospital, Longview, Texas. He entered service July eighth after completing his internship at the Pontiac General Hospital. His last assignment was at Carlisle Barracks, Pennsylvania. After leaving Longview he will proceed to quarters in North Carolina.

The following note is from Captain Forest M. Kendall, of Alexandria, who is with the Army Air Force: "Despite the current optimism, I am still anticipating a prolonged absence from home so, to help relieve the isolated feeling one gets from being 'somewhere in Corsica,' will you please forward *THE JOURNAL* to my new address?"

After eight months of sea duty as a medical officer on assault transports in European and North African waters, Lieutenant Commander Maurice V. Kahler, of Indianapolis, was flown here from Naples. Commander Kahler was in both invasions of France and said, "Normandy was pretty tough and the casualties were heavy, but southern France was not so bad." His duty was the evacuation of casualties, chiefly naval personnel whose ships had been sunk. Many of these men were forced to remain in the water for long periods of time, often as many as four hours, which made the problem a great deal more serious from a medical standpoint.



Commander Thomas P. Rogers

charge of the main dispensary. He was reporting to Camp Blanding for further duty.

While en route to Camp Blanding, Florida, Commander Thomas P. Rogers, of Indianapolis, stopped in Indianapolis for a short visit. He has completed eighteen months of service in the Naval medical activities on Treasure Island, where he was medical officer in

After being stationed at Camp Barkeley, Texas, Major William M. Loehr, of Indianapolis, has gone overseas. He is on duty with a general hospital.

Two Indianapolis doctors, Colonel Thomas S. Shields, and his brother, Captain Jack E. Shields, met recently for the first time in two years. Both doctors are stationed in Italy.

The Purple Heart has been awarded to Captain Floyd S. Martin, of Goshen, for wounds received from a shell fragment when he, together with his ambulances and their first aid men, was ambushed during a battle near the front. Captain Martin is a battalion surgeon, and has been in France since the landings in June.

Captain Harry Sandoz, of South Bend, is with Army engineers in the first zone behind the front lines. They are laying an oil line in . . . Because there is a shortage of medical officers in his division, the work is heavy, and the patients include a few civilians who straggle in with shrapnel wounds, and so forth.

We recently learned that Lieutenant Charles F. Gillespie, of Indianapolis, has gone overseas with an evacuation hospital. He was formerly at Fort Jackson, South Carolina.

The latest information about Captain Charles O. Weddle, of Lebanon, is that he has just landed in New Guinea. Before that he had been stationed at the Alexandria Army Air Base, Alexandria, Louisiana. Captain Weddle states that he is quite happy, and is with a fine outfit. He wears the flight surgeon's wings.

From New Guinea Captain James L. Bartle, of Knightstown, writes: "Our outfit has been here about seven months and is just now beginning to set up for operation. Meantime, we have been sitting in the jungle, rain, and mud; fighting bugs and mosquitoes; eating 'C' rations—we have very few fresh vegetables or fruits, everything is canned. The temperature is very hot during the day, but at night blankets are welcome."

"Part of last year I spent in Africa. This year finds me in the land of extremes," writes Captain E. G. Neidballa, of Bristol, who is on duty now with a station hospital somewhere in India. "So far I have not seen the mystery and magic I read about.

"I will appreciate it if you will forward the JOURNAL to my current address, for it will give me a means of keeping 'posted' on the professional activities in the state."

Following is an excerpt from a press release by the GHQ Public Relations Office: "Major John M. Sullivan, former Terre Haute physician who left for overseas duty in February of this year, is now in New Guinea with the evacuation hospital of which he is receiving officer. Commissioned a captain in the Medical Corps in July, 1942, Major Sullivan is now a veteran of the Hollandia operation, which cut off the entire Japanese Eighteenth Army and again advanced General Douglas MacArthur's forces several hundred miles nearer the Philippines."

V-mail brings us the following information from Major John M. Sullivan, of Terre Haute: "This finds me somewhere in New Guinea with an evacuation hospital. Major Paul Hill, of Cambridge City, and Major Alfred Scales, of Oakland City, are the other members of the Indiana delegates in the unit. We are getting THE JOURNAL and news letter fairly regularly and with a great deal of anticipation."

On duty with a military police battalion, Captain Robert D. Spindler, of New Castle, is now serving in India.

Landing on an island in the Pacific about the first of August, Lieutenant Commander Keith E. Selby, of South Bend, went into the thick of the action. His group watched the bombardment from the outside, awaiting the signal to go in. When they did, they found nothing but devastation, suffering, and disease. The Marines have spent much time ridding the island of snipers. They also fight flies, mosquitoes, dysentery, dengue fever, stench and filth. The rain is ceaseless and the whole place is a mud hole. In the midst of all this destruction, the harbor and the mountains in the background are beautiful, and the beauty of the sunsets is unsurpassed.

From Camp White, Oregon, Major B. K. Zaring, of Columbus, has gone to Santa Barbara, California, where he is attached to a service unit.

A most entertaining letter, written by Captain William R. Ori, formerly of Mishawaka, was published in the *St. Joseph County Medical Society Bulletin*, which we take the liberty of reprinting:

"I am living in a Neissen hut with four other officers. The hut, which has a concrete floor, is quite comfortable. One half is a bedroom, and the other half, which has a mess table for writing, is our living room. Twenty-five yards from our hut is the Officer's Club. The food is pretty good here—we have a lot of pork, beef two or three times a week, and chicken on Sunday. The chicken is sometimes good—bad most of the time. I think I miss good ice cold milk about as much as anything. The fresh milk here is not safe to drink and is not used by the Army. Powdered milk is O.K. on cereals, and is served mornings. Ice cream made with powdered milk is fair. What do I want sardines for?—to eat, my dear! Just returned from a medical meeting at a general hospital—quite a novelty—a medical meeting! Last night we had a costume dance. One of the boys went as an African head hunter—black face, grass skirt, nose ring, a tor silk hat, long chain of teeth around his neck, and he also carried a saber made of teeth. He put a sixpence (which is the size of a dime) in each nostril to flare them, and today he missed one. He appeared today with a patch over one eye because of an injury innocently obtained but, of course, no one believed him. After the party some of us went to one of the other huts. The African head hunter offered one of the boys a drink. As it turned out, it was lighter fluid—the fellow drank two or three swallows before he realized it wasn't whiskey. It is the same old story tonight—busy—tired—worked late—I am worn to a 'nubbin.' Believe it or not, I am getting a forty-eight-hour leave. I am going someplace for a rest. When I start dreaming about my work—casts, amputations, et cetera, it is time to get away."

A letter from Major Marion W. Hillman, of South Bend, telling of a short vacation trip which he made around the Island of Hawaii with a group of six officers, was published in the *St. Joseph County Bulletin*, and it describes Hawaii so interestingly that we take the liberty of quoting it in part:

"Leaving, we flew above the clouds and had a beautiful day, for although the sun was out nicely there were many clouds, and we flew at 8,500 to 10,500 all the way to Hilo. When we got over Hilo we found a hole in the clouds and circled down. Finally, we got a ride with some officer in a jeep and were taken to the Special Service Office in the city. We left requests for reservations at the K.M.C. (Kilauea Military Camp), and also had them make reservations for us to go around the Island on a bus trip. We went over to the Officers' Club in Hilo, which is really the Elks Club turned over to the Army and Navy for the duration, I guess. The quarters for the officers were small cabins or cottages which are designed for three or four individuals.

"The K.M.C. sits on the edge of the crater area, so that it is just a short walk across the grounds and the road, and then over to the edge. The crater at this point is about 5-600 feet deep, and the walls are very steep. The floor of the crater from this height looked quite smooth, full of ripples, and very black. We could see the fire pit in the distance on the other side from which the lava had emerged. Along this particular side there are still a good many steam cracks, so called, where steam emerges and causes quite a cloud which spreads over the crater and gives a very misty appearance. The trail led down rather steeply through a dense jungle of trees, ferns, and giant tree ferns. The whole crater is about

three miles across, and the distance is very deceiving when viewed from the top. Finally we arrived at the fire pit. This is an immense hole, over seven hundred feet deep and a half a mile across, with the black hardened lava on the floor. There are some rest houses at the fire pit, and where there used to be a wide, smooth-surfaced highway near this point, it is now all plowed up because it was thought the Japs might land planes there. A great many places on the Island have had posts put up along the roads at short intervals to stop a plane from landing without cracking up.

"We rested for a time here and then started the journey back to the K.M.C., finally getting away about eleven, with five officers and five enlisted men in a car called a 'Sampam,' which is somewhat like a station wagon except that there are seats along the back and the sides which would accommodate from ten to twelve people. We drove out to Hilo, and immediately began to go through vast fields of cane. Our road ran along the coast most of the way and the slope of the mountains began some distance inland. The land is irrigated with flumes that run for miles over the fields, and in many cases there are large flumes that are used to transport the cut cane to mills for processing, since that is easier than hauling it by truck or train.

"We continued through the cane fields, and finally came to the Waipio Valley. This is a wide, deep valley that runs back from the coast, and the only access to it is down a steep trail which is muddy and has many rocks like cobblestones set in the mud. It is much too steep for a car, and so it is only a foot path and a trail for the burros. In going down we met about a dozen of them coming up, each one loaded with two sacks of Tara root. There is a settlement of Chinese and Hawaiians, and probably some Japs living down there, and they are pretty well isolated from the rest of the inhabitants. The coast line at this point presents a very pretty picture with the white caps breaking in on the beach, and the upper ridges of the valley sheathed in white clouds.

"As we approached the coast again we could see for great distances, and the little town where we were going could be seen with its vari-colored roofs standing out in the distance. We arrived in the little town of Kailua and stopped at the Kona Inn. This is a rather famous hostelry, and the area about this part of the Island is slow moving and very rural. The following morning the first place we went was to the Summer Palace or the Hawaiian Museum. After leaving the museum we went up in the hills on a very winding road, and noticed the change in temperature very quickly. Beautiful vegetation was all along the way, and also coffee trees or bushes. The coffee berries grow singly along the branches of the bushes and are picked singly. The Kona district apparently is famous for its coffee, and the trees are planted on the hillsides not very far from the road. There were mills for processing the beans, and long drying platforms. The papayas are everywhere, and evidently the people use them freely as well as export them.

"The following day we started out to complete our trip around the Island, and back to Hilo. We continued through narrow roads; saw many mongoose, and a great many flowering trees. The road was fairly high up on the hillside, but we could still see the shoreline of the coast most of the way, and we were high enough so that a great deal of the time the land below us looked like a huge map laid out before us. We passed through a large forest preserve that had many Ohia trees. They make a very colorful sight with their red flowers standing out all over the trees. From here we got into the lava flow areas again from Mauna Loa. We flew low over the Island and were able to see the land below very well. The mountains were on display, and the waterfalls and all. It was very interesting.

"We went on into Honolulu, and later got our bus for our home station, and thus completed a very enjoyable trip. But it was good to get back here after the little vacation, and we could look at things with an added zest for having been away."

News Notes

Major William L. Sharp and Miss Jean Montgomery, both of Anderson, were married September second in the post chapel at Camp Maxey, Texas.

Mrs. Ronald Hazen, director of the Indiana Division for Cancer Control, recently presented a check to the Indiana University Medical Center, for aid in supporting a pathology fellowship at the medical center.

Dr. W. F. Hughes, Jr., the son of our Dr. W. F. Hughes, of Indianapolis, had the honor of being represented on the program of the American Academy of Ophthalmology and Otolaryngology at its annual meeting held in Chicago on October twelfth.

Dr. William A. Karsell, of Bloomington, has been elected president of the newly-organized Monroe County Society for the Crippled. The organization's aims are an early discovery of mental and physical handicaps, care and treatment, education, and vocational training.

Dr. Charles W. Morris, of Rockville, has been transferred from the medical department of the Wabash River Ordnance Plant to a larger DuPont plant at Carney's Point, New Jersey, where he will be medical supervisor. The plant at Carney's Point is one of the oldest of the many DuPont plants.

NATIONAL VENEREAL DISEASE CONTROL CONFERENCE

A National Venereal Disease Control Conference will be conducted under the auspices of the United States Public Health Service, at St. Louis, Missouri, November 9, 10 and 11. Leading experts on venereal disease control from the United States, and from some other nations, will consider international and post-war venereal disease control, and other specialized subjects.

Dr. Kathryn Whitten, of Fort Wayne, headed the drive to send an emergency medical field set to the United States Amphibious Forces, through the Medical and Surgical Relief Committee of America, which since its organization in 1940 by leading doctors throughout the nation have distributed three hundred seventy field kits and more than \$675,000 worth of drugs, instruments, vitamins, and concentrated foods to the peoples and fighting forces of the United Nations. The field set is equipped with drugs, antiseptics, bandages, and other supplies, and is to provide emergency care to fighting crews during combat duty.

Dr. David A. Boyd, Jr., of Indianapolis, has been employed as the first full-time director of the Indianapolis City Hospital's neuropsychiatric ward. In the past, treatment has been provided through the voluntary services of psychiatrists, but no one person was in charge. This step was taken in anticipation of an increase in mental cases, and Doctor Boyd will direct expansion of the ward's present capacity of fifty-five to more than one hundred fifty beds, as a part of the post-construction program at the hospital.

MEDICAL OFFICERS NEEDED

The Civil Service Commission has announced a new examination for Rotating Internship and Psychiatric Resident positions at St. Elizabeth's Hospital, in Washington, D. C. The positions pay \$2,433 a year, including overtime pay. Applications will be accepted until the needs of the service have been met. Application forms may be secured at first- and second-class post offices, from the Commission's regional offices, or direct from the United States Civil Service Commission, Washington 25, D. C.

PHYSICIANS NEEDED BY THE UNITED NATIONS RELIEF AND REHABILITATION ADMINISTRATION

The United Nations Relief and Rehabilitation Administration has immediate need for about forty physicians. In order to fill this requirement, they wish to get in direct touch with those members of the Office of Civilian Defense, United States Public Health Service Affiliated Units, who can be spared from their present civilian duties. Anyone interested should notify C. R. Bird, M.D., Chairman, Procurement and Assignment Service for Indiana, 1021 Hume-Mansur Building, Indianapolis 4, Indiana.

The American Society for the Control of Cancer, which has been engaged in educating the public concerning that disease since 1913, has announced a legal change in its name, indicating its broader and more active program. The new name is "American Cancer Society." At the same time a change in the name of the society's lay educational organization, which since its inception in 1936 has been called the Women's Field Army, has been announced. In recognition of the fact that men as well as women are vitally concerned in the work, it is to be called "The Field Army." The American Cancer Society plans to expand its efforts to obtain funds from the public for cancer research and diagnosis and treatment, as well as to educate the public concerning cancer.

EXAMINATIONS**AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY**

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 3, 1945. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the Secretary by November 15, 1944.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

**THE CHICAGO MEDICAL SOCIETY
SECOND ANNUAL CLINICAL CONFERENCE**

The Chicago Medical Society is holding its Second Annual Clinical Conference at the Palmer House, Chicago, on February 27-28 and March 1, 1945. The sponsoring of this annual clinical conference for physicians of the Middle West has become an important function of the Chicago Medical Society following its inauguration last spring.

The Committee is already under way in securing speakers on important subjects for the 1945 conference. Exhibits, both technical and scientific, will be greatly increased.

Further information will be given later. In the meantime, early reservations at the Palmer House, Chicago, are recommended.

SEVENTH ANNUAL FORUM ON ALLERGY

The Seventh Annual Forum on Allergy will be held in the Hotel William Penn, Pittsburgh, Pennsylvania, on Saturday and Sunday, January 20-21, 1945. This is a meeting to which all reputable physicians are invited and where they are offered an opportunity to bring themselves up to date in this rapidly-advancing branch of medicine by two days of intensive post-graduate instruction. For instance, the twelve study groups, any two of which are open to him, are so divided that those dealing with ophthalmology and otolaryngology, pediatrics, internal medicine, dermatology and allergy run consecutively. During these two days almost every type of instructional method is employed—special lectures by outstanding authorities, study groups, pictures, demonstrations, symposia and panel discussions.

On Friday evening preceding the forum, the American Association of Allergists for Mycological Investigation will hold its annual meeting at which time the results of their cooperative research on the Allergy to Fungi will be reviewed. All reputable physicians and scientists are invited to attend this interesting summarization of a year of brilliant cooperative research. For further information, copies of the book and registration, write Jonathan Forman, M.D., Director, 956 Bryden Road, Columbus 5, Ohio.

INDIANA UNIVERSITY NEWS NOTES

Two Indiana University medical school men, Dr. David A. Boyd, Jr., a member of the faculty, and Dr. Kenneth Kohlstaedt, a graduate, have been appointed to head divisions of the Indianapolis City Hospital.

Dr. Boyd has been made the first full-time director of the City Hospital's neuropsychiatric ward. He will continue to serve in his present position as professor of psychiatry in the School of Medicine.

Dr. Kohlstaedt, who received his medical degree from Indiana University and who has been assistant superintendent of the City Hospital, will become director of the famous Lilly Clinic, sponsored by Eli Lilly and Company.

In celebration of the twentieth anniversary of the opening of the James Whitcomb Riley Hospital for Children, the board of trustees of Indiana University honored the original incorporators and the board of governors of the hospital Friday, October 6. Hugh McK. Landon, chairman of the Fletcher Trust Company and president of the hospital board; William Lowe Bryan, president emeritus of Indiana University, and Herman B. Wells, president of the University, spoke at the luncheon at the hospital. Judge Ora L. Wildermuth of Gary, president of the Indiana University board of trustees, spoke on behalf of the trustees, as the Riley Hospital is a part of the Indiana University Medical Center.

The Selection Committee for entrance to the Indiana University School of Medicine has announced the names of fifty-two pre-medical students who have been named to begin their professional medical training at the opening of the second semester, December 28. These students are now completing their pre-medical work at Indiana University and other schools.

In commenting on the size of the class now named, Dr. W. D. Gatch, dean of the medical school, said that it is much smaller than that usually chosen due to the limited number of men available. "I had not expected that the committee on admissions would find as many as fifty-two students who would meet the requirements for admission," Dean Gatch said. "These students, together with the students sent us by the Army and Navy, will give us a class almost as large as we had in peacetime. Future classes will undoubtedly be small because the supply of pre-med students is almost exhausted. I hope that the students accepted will feel that it is their patriotic duty to work as hard as they can."

Men selected for the class and subject to military service have been placed on an inactive military basis until they enter the medical school, at which

time they will be called to active duty and receive quarters, subsistence, fees and books, and an Army private's or Navy midshipman's pay of fifty dollars a month while pursuing their professional training.

Students named to enter the next medical class at the University are:

Robert M. Abel, Elkhart; Esther E. Anderson, Hammond; Marion R. Anthoulis, Gary; Eddie R. Apple, French Lick; Paula J. Bailey, Fort Wayne; Richard C. Blaney, East Chicago; Jo Ann Booze, Bloomington; Harold E. Bowman, Attica; Marilyn R. Caldwell, Indianapolis; Frank R. Daugherty, Jr., Wabash; Lenore S. DeGrazia, Valparaiso; Robert A. Driver, Fort Wayne; Phyllis Ann Fenn, Tell City; Edith L. George, Seymour; Milton H. Gotlib, Fort Wayne; Elmer D. Habegger, Berne; Edgar E. Hamer, Indianapolis; Sarah M. Ingle, Sacramento, California; William B. Johnson, Jr., Indianapolis; Nick Kerkez, Gary; Ernest W. Klatte, Jr., Clay-ton; Elmer L. Koch, Lawrence; Maurice E. Krahl, Indianapolis; Jane Krider, Brazil; Gilbert Landis, Toledo, Ohio; Gladys J. Leedy, North Manchester; Russell Lavengood, Marion; Dave Lozow, Gary; Robert E. McCullough, Brazil; Patricia Ann McGrath, Indianapolis; James S. McLean, Hammond; Joseph C. Muhler, Fort Wayne; Vivian E. Nevue, Richmond; Byron J. Park, Richmond; Norman L. Paul, Buffalo; Joseph G. Peil, South Bend; Ada R. Perel, Whiting; Francis W. Price, Indianapolis; Harold J. Rarick, Walkerton; Robert C. Reed, Terre Haute; William D. Ritchie, Evansville; Mayer D. Roseman, Philadelphia, Pennsylvania; Morris Saperstein, New York City; Albert J. Schneider, Bloomington; Robert V. Seglin, Hammond; Lowell H. Steen, East Chicago; Gerald Sullivan, Alexandria; Myron Volk, Cleveland Heights, Ohio; Alvin F. Volkman, Evansville; Robert O. Waldorf, Albany; John W. Wilson, Bloomington, and Elsie F. Zeps, Indianapolis.

VOICE OF MEDICINE

LAY DOMINATION

September 21, 1944.

Dear Editor:

In your August issue of the state JOURNAL there was an article entitled "Lay Domination of Medical Practice," by W. D. Gatch, M.D., Dean of the Indiana University School of Medicine. It was an excellent article, and especially appealed to the group of doctors in Grant County.

Individually, we felt it so important to the private practice of the medical profession that the article was taken up and read at the county medical society meeting. A full discussion of the problems mentioned was held. It was the unanimous consensus of the society that it go on record as being heartily in accord with the substance of Doctor Gatch's article. We wish to suggest that other county societies take the time and trouble to read it fully and carefully, and no doubt from their discussion they will probably get the viewpoint we obtained.

Doctor Gatch is to be congratulated on the time and thought he has given to writing such a timely paper.

Faithfully yours,
RUSSELL W. LAVENGOOD, M.D.,
Marion.

Deaths

Florence Eva Dillan, of Indianapolis, noted medical reporter, died suddenly at a local hospital on October 12, 1944. She was born in West Middlesex, Pennsylvania, March 9, 1867, and came to Indianapolis forty years ago, where she had continued in her profession as a medical and court reporter up until the time of her death, having served as the head reporter at the annual meeting of the Indiana State Medical Association a week earlier. She was an expert reporter in the medical field, and had endeared herself to all who knew her. Her memory will linger on not only in the annals of history but in the hearts of the entire medical profession.

William A. D. Barnhill, M.D., of LaOtto, died September twenty-fifth, on his eighty-fourth birthday. He was a graduate of the Cleveland Medical College, Homeopathic, in 1893, and had practiced almost fifty years when he retired two years ago.

Vernard Reno Hodges, M.D., of Indianapolis, died September fourteenth, at the age of sixty-two. He was a graduate of Rush Medical College, and had practiced medicine in Arlington and vicinity for some time, leaving there about two years ago to live in Indianapolis.

Thomas Monroe Jones, M.D., of Anderson, died September nineteenth, at the age of sixty-seven. He was a graduate of Johns Hopkins University School of Medicine, in Baltimore, in 1902, and later took postgraduate work in Vienna. Doctor Jones served as a major in a medical group in England in World War I. He was one of the founders of St. John's Hospital x-ray department and laboratory, and helped organize the hospital staff, and also furnished its first operating room. He limited his practice to surgery. Doctor Jones was a member of Madison County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Henry Carter Metcalf, M.D., of Connersville, died on September twenty-third at the age of fifty-six. He was a graduate of the University of Louisville



Henry Carter Metcalf, M.D.

School of Medicine. He limited his practice to otorhinolaryngology, and had practiced in Connersville since receiving his honorable discharge from the Army in 1919. He served overseas as a first lieutenant with the 132nd Engineers during World War I. Doctor Metcalf was president of the Indiana State Board of Health, and a member of the Fayette County Board of Health, and had at one time served as its secretary. He had served two terms as county coroner. Doctor Metcalf was a member of the Fayette-Franklin County Medical Society, and served as its president in 1932-33. He was a member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

Edwin William Dyar, M.D., of Ossian, died September eleventh, at the age of sixty-four. He had been in failing health for the past five years, and had been retired for that length of time. Doctor Dyar was a graduate of the Medical College of Indiana, at Indianapolis, and was a member of the Wells County Medical Society, the Indiana State Medical Association, and the American Medical Association.

John Franklin Cameron, M.D., of Hamilton, died suddenly at his home, on September twentieth. He was eighty-nine years of age. Doctor Cameron was a graduate of Rush Medical College, in Chicago, in 1880, and had practiced medicine sixty years before his retirement four years ago. Before entering Rush Medical College he taught for several years in the country schools of Steuben County. Doctor Cameron was a member of the Steuben County Medical Society and the American Medical Association, and was an honorary member of the Indiana State Medical Association.

Nathaniel Austin Cary, M.D., of Oakland, California, died September twelfth at a hospital in Oakland. Doctor Cary was a former member of the Indiana State Medical Association, having practiced in Crawfordsville for a number of years. He was a graduate of the Indiana Medical College, School of Medicine of Purdue University, at Indianapolis, in 1906. He was sixty-two years of age.

James Lyle Fortune, M.D., of Terre Haute, died September twenty-sixth at the age of sixty-four. He was a graduate of the Medical College of Indiana, at Indianapolis, in 1903, and had practiced in Terre Haute for forty years. Doctor Fortune had been an examining physician for the Redstone Arsenal, of Huntsville, Alabama, for the past year, and was returning to Terre Haute for a visit when he suffered a heart attack.

Harry Evert Grishaw, M.D., of Tipton, died at his home on September twenty-eighth after a long illness. He was a graduate of the Central College of Physicians and Surgeons, at Indianapolis, in 1897, and had practiced in Tipton County for nearly half a century. He was seventy-one years of age. Doctor Grishaw was a member of the Tipton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Everett Thomas Zaring, M.D., of Terre Haute, died September twentieth, at the age of sixty-one. He graduated from the Indiana Medical College, School of Medicine of Purdue University, at Indianapolis, in 1906. At the time of his death he was deputy coroner of Vigo County. Doctor Zaring was especially interested in anesthesia, and was a member of the American Society of Anesthesia. He was also a member of the Vigo County Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Dennis L. McAuliffe, M.D., of North Vernon, died September eighteenth, at the age of seventy-nine. He was a graduate of the Miami Medical College, in Cincinnati, in 1902, and had practiced for the past thirty-seven years in North Vernon. He limited his practice to internal medicine. Doctor McAuliffe had served as secretary of the Jennings County Medical Society from 1918 until the time of his death; he was an honorary member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COUNCIL

First Meeting

(Indianapolis Session, October 3, 1944)

The first meeting of the Council was held in the Kneipe Room of the Murat Temple, at 12:30 P.M., Tuesday, October 3, 1944, the chairman, Dr. F. T. Romberger, of Lafayette, presiding.

Roll call showed the following members present:

Councilors:

First District.....I. C. Barclay, Evansville
 Second District.....H. C. Wadsworth, Washington
 Third District.....A. P. Hauss, New Albany
 Fourth District.....J. C. Elliott, Guilford
 Fifth District.....A. M. Mitchell, Terre Haute
 Sixth District.....W. U. Kennedy, New Castle*
 Seventh District.....W. L. Porteus, Franklin
 Eighth District.....E. H. Clauser, Muncie
 Ninth District.....F. T. Romberger, Lafayette
 Tenth District.....W. H. Howard, Hammond
 Eleventh District.....C. S. Black, Warren
 Twelfth District.....A. Jerome Sparks, Fort Wayne
 Thirteenth District.....Alfred Ellison, South Bend
 * It was announced that Dr. W. U. Kennedy, of New Castle, had been elected to fill the unexpired term of Dr. Samuel Kennedy, of Shelbyville, who had resigned as councilor of the Sixth District.

Retiring Councilor:

Eleventh District.....Ira Perry, North Manchester

Officers:

J. T. Oliphant, Farmersburg, president.
 N. K. Forster, Hammond, president-elect.
 A. F. Weyerbacher, Indianapolis, treasurer.
 E. M. Shanklin, Hammond, editor of THE JOURNAL.

Members of Executive Committee:

Cleon A. Nafe, Indianapolis, chairman.
 C. H. McCaskey, Indianapolis.
 Albert Stump, Indianapolis, attorney.
 T. A. Hendricks, executive secretary.

Member of A.M.A. Board of Trustees:

R. L. Sensenich, South Bend.

Delegates to the A.M.A.:

H. G. Hamer, Indianapolis.
 Don F. Cameron, Fort Wayne.
 F. S. Crockett, Lafayette.

General Arrangements Committee:

Bert Ellis, Indianapolis, chairman.

Legislative Committee:

Norman M. Beatty, Indianapolis }
 J. William Wright, Indianapolis } Co-chairmen.
 J. R. Newcomb, Indianapolis.

The minutes of the midwinter meeting of the Council, as printed in the February, 1944, issue of THE JOURNAL, were accepted as printed.

No additions to or comments were made on the formal councilor reports which were printed in the September JOURNAL.

The chairman asked that dates for next year's district meetings be sent to the headquarters' office as soon as possible in order to avoid conflicts.

New Business

1. *Auditing Committee report.* Upon the motion of Dr. Sparks, seconded by Dr. Wadsworth, the report of the Auditing Committee, published in the September JOURNAL, was accepted.

2. *Malpractice insurance.* Dr. Nafe spoke on the arrangements made by the Executive Committee for group malpractice insurance for the members of the association.

3. *Health insurance.* Dr. Howard spoke of the recommendations of the Permanent Study Committee on Health Insurance, and the subject was discussed by the Council.

Dr. Sensenich discussed the question from the standpoint of the American Medical Association.

It was announced that Dr. Crockett had been appointed chairman of a special reference committee which would consider Dr. Howard's report, and that this committee would be in session throughout Wednesday to discuss that report and all phases of the prepayment medical insurance question which might be brought to its attention. Dr. Crockett expressed the hope that anyone who had anything to discuss in regard to this subject would avail himself of the opportunity of appearing before this special reference committee.

4. *Legislative activities.* Dr. Beatty discussed legislative problems.

5. *Raise in dues.* Following a report by Dr. Weyerbacher, Dr. Nafe reported that the Executive Committee recommended to the Council that a war assessment of \$5 per member be authorized by the Council for the coming year. Dr. Wadsworth made the following motion, which was passed: "I move that the Council recommend to the House of Delegates a war assessment of \$5 per member per year, beginning January 1, 1945, for the duration of the war and one year thereafter."

6. *Election of Editor of THE JOURNAL for 1945.* Upon the motion of Dr. Wadsworth, seconded by Dr. Ellison and Dr. Barclay, Dr. E. M. Shanklin, of Hammond, was re-elected editor of THE JOURNAL for 1945.

7. *Election of Editorial Board members.* Upon motions of Dr. Wadsworth and Dr. Barclay, Dr.

Bert Ellis, of Indianapolis, and Dr. Charles N. Combs, of Terre Haute, were elected members of the Editorial Board, to serve for three years and to succeed Dr. J. O. Ritchey, of Indianapolis, and Dr. R. V. Hoffman, of South Bend.

8. *Commercial sponsorship of radio programs.* Dr. Homer Hamer brought up the question of having a commercial firm sponsor the "Doctor Good-health" programs which are broadcast by the Indiana State Medical Association. Dr. John Ray Newcomb and Dr. R. L. Sensenich discussed this question, and the Council authorized the Bureau of Publicity and Dr. Newcomb to study the matter further with the understanding that the Council was not opposed to having a commercial sponsor for the program. The precedent for this is the fact that the Schenley Laboratories sponsor a program broadcast with the approval of the American Medical Association.

9. *Postwar program of the State Board of Health.* The Council was informed that the postwar program of the State Board of Health was to be presented to the House of Delegates for its consideration.

Date for Midwinter Council Meeting

Upon the motion of Dr. Sparks, seconded by Dr. Barclay, Sunday, January 21, 1945, was set for the midwinter meeting of the Council.

No further business appearing, the Council adjourned until Thursday morning, following the second meeting of the House of Delegates.

THOMAS A. HENDRICKS,
Executive Secretary.

THE COUNCIL

Second Meeting

(Indianapolis Session, October 5, 1944)

The second meeting of the Council convened immediately following the adjournment of the House of Delegates, Thursday morning, October 5, 1944, with Dr. F. T. Romberger, the chairman, presiding.

Roll call showed the following members present:

Councillors:

- First District.....I. C. Barclay, Evansville
- Second District.....H. C. Wadsworth, Washington
- Third District.....A. P. Hauss, New Albany
- Fifth District.....A. M. Mitchell, Terre Haute
- Sixth District.....W. U. Kennedy, New Castle
- Seventh District.....W. L. Portteus, Franklin
- Eighth District.....E. H. Clauser, Muncie
- Ninth District.....F. T. Romberger, Lafayette
- Tenth District.....W. H. Howard, Hammond
- Eleventh District.....C. S. Black, Warren
- Twelfth District.....A. Jerome Sparks, Fort Wayne
- Thirteenth District.....Alfred Ellison, South Bend

Officers:

- J. T. Oliphant, Farmersburg, president.
- N. K. Forster, Hammond, president-elect 1944.
- Jesse E. Ferrell, Fortville, president-elect 1945.

Executive Committee:

- C. A. Nafe, Indianapolis, chairman.
- Albert Stump, Indianapolis, attorney.
- T. A. Hendricks, executive secretary.

A.M.A. Board of Trustees Member:

- R. L. Sensenich, South Bend.
- Dr. Martin I. Olsen, Des Moines, Iowa.

Special Meeting of House of Delegates

Upon the motion of Dr. Mitchell, Sunday, November 12, 1944, was set as the date for the special meeting of the House of Delegates, at which time the subject of health insurance is to be considered further.

Industrial Health Conference

Dr. E. S. Jones, chairman of the Committee on Industrial Health, appeared before the Council to ask if it was the wish of the Council that an Industrial Health Conference be held in 1945. He stated that such a meeting entails a great amount of work and expense, and the 1944 meeting was poorly attended. The Council went on record as approving the holding of such a conference again in 1945.

No further business appearing, the Council adjourned.

THOMAS A. HENDRICKS,
Executive Secretary.

INDIANA STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES
(INDIANAPOLIS SESSION, 1944)

First Meeting

The first meeting of the House of Delegates of the 1944 session was held in the Murat Theater, Indianapolis, convening at 4:00 P.M., October third, the president, Dr. J. T. Oliphant, of Farmersburg, presiding.

On motion of Dr. George R. Daniels, duly seconded, the attendance slips which had been distributed were made to constitute the roll call of the House. These slips showed the following members present:

County	Delegates
Allen	M. B. Catlett, Fort Wayne M. R. Lohman, Fort Wayne William C. Wright, Fort Wayne
Bartholomew	L. F. Beggs, Columbus
Benton	V. L. Turley, Fowler
Boone	Ralph J. Harvey, Zionsville
Carroll	Max R. Adams, Flora
Cass	B. W. Egan, Logansport
Clark	E. P. Buckley, Jeffersonville
Clay	J. F. Maurer, Brazil
Clinton	F. A. Beardsley, Frankfort
Dearborn-Ohio	G. S. Fessler, Rising Sun
Delaware-Blackford	Clay A. Bail, Muncie
Dubois	Paul J. Blessinger, Jasper

County	Delegates
Elkhart	A. C. Yoder, Goshen
Fayette-Franklin	R. H. Elliott, Connersville
	E. M. Glaser, Brookville
Fulton	A. E. Stinson, Rochester
Floyd	C. E. Briscoe, New Albany
Gibson	C. M. Clark, Oakland City
Hamilton	C. M. Donahue, Carmel
Hancock	J. E. Ferrell, Fortville
Harrison	William E. Amy, Corydon
Hendricks	C. B. Thomas, Plainfield
Howard	Elton R. Clarke, Kokomo
Huntington	G. M. Nie, Huntington
Jackson	L. H. Osterman, Seymour
	G. H. Kamman, Seymour (Alt.)
Jay	George V. Cring, Portland
Jefferson	Nicholas A. Kremer, Madison
Jennings	D. W. Matthews, North Vernon
Johnson	Oran A. Province, Franklin
Lake	H. W. Eggers, Hammond
	C. M. Jones, Whiting
	C. R. Pettibone, Crown Point
	P. Q. Row, Hammond
	G. L. Verplank, Gary
Lawrence	Claude Dollens, Oolitic
Madison	A. W. Elsten, Anderson
	C. S. Wright, Anderson
Marion	Otto H. Bakemeier, Indianapolis
	John E. Dalton, Indianapolis (Alt.)
	E. V. Hahn, Indianapolis
	A. H. Harold, Indianapolis (Alt.)
	Goethe Link, Indianapolis
	M. W. Manion, Indianapolis
	Ben B. Moore, Indianapolis
	W. P. Morton, Indianapolis
	R. H. Moser, Indianapolis
	Roy V. Myers, Indianapolis
	Harold C. Ochsner, Indianapolis
	J. O. Ritchey, Indianapolis
	Ernest Rupel, Indianapolis
	Russell A. Sage, Indianapolis
	William Niles Wishard, Jr., Indianapolis
Marshall	A. A. Thompson, Tyner
Miami	F. M. Lynn, Peru
Monroe	Naomi Dalton, Bloomington
Montgomery	T. Z. Ball, Crawfordsville
Noble	A. L. Fipp, Rome City
	C. E. Munk, Kendallville (Alt.)
Pike	John T. Kime, Petersburg
	T. R. Rice, Petersburg (Alt.)
Porter	John R. Frank, Valparaiso
Posey	J. R. Ranes, Mount Vernon
Randolph	William S. Dininger, Winchester
Rush	C. C. Atkins, Rushville
St. Joseph	Morris Balla, South Bend
	F. R. Nicholas Carter, South Bend
	A. S. Giordano, South Bend
Shelby	W. D. Inlow, Shelbyville
Spencer	John H. Barrow, Dale
Sullivan	J. R. Crowder, Sullivan
Tippecanoe	Gordon A. Thomas, Lafayette
	Earl Van Reed, Lafayette
Tipton	S. M. Cotton, Goldsmith
Vanderburgh	Robert R. Acre, Evansville
	C. W. Cullnane, Evansville
	Minor Miller, Evansville
Vigo	A. W. Cavins, Terre Haute
	Ernest O. Nay, Terre Haute
Wabash	O. G. Brubaker, North Manchester
Washington	Claude B. Paynter, Salem
Wayne-Union	Harry P. Ross, Richmond
	W. A. Thompson, Liberty
Wells	H. B. Annis, Bluffton
Whitley	Paul A. Garber, South Whitley

Councilors

First District	I. C. Barclay, Evansville
Second District	H. C. Wadsworth, Washington
Third District	A. P. Hauss, New Albany

County	Delegates
Fourth District	J. C. Elliott, Guilford
Sixth District	W. U. Kennedy, New Castle
Seventh District	W. L. Portteus, Franklin
Eighth District	E. H. Clauser, Muncie
Ninth District	F. T. Romberger, Lafayette
Tenth District	W. H. Howard, Hammond
Eleventh District	C. S. Black, Warren
Twelfth District	A. Jerome Sparks, Fort Wayne
Thirteenth District	Alfred Ellison, South Bend

Past Presidents

W. R. Davidson, Evansville
E. M. Shanklin, Hammond
Charles N. Combs, Terre Haute
George R. Daniels, Marion
F. S. Crockett, Lafayette
Joseph H. Weinstein, Terre Haute
E. E. Padgett, Indianapolis
R. L. Sensenich, South Bend
K. R. Ruddell, Indianapolis
M. A. Austin, Anderson

Officers

J. T. Olipnant, Farmersburg, President
A. F. Weyerbacher, Indianapolis, Treasurer

Delegates to A.M.A.

D. F. Cameron, Fort Wayne
H. G. Hamer, Indianapolis

THE PRESIDENT: Doctor Amy, is there a quorum present?

WILLIAM E. AMY, Chairman, Credentials Committee: There is a constitutional quorum present.

THE PRESIDENT: Twenty constitute a constitutional quorum, and there being that many present the House of Delegates is in order.

The By-Laws may be amended at any annual session by a *majority vote of all the delegates present* at that session, after the amendment has laid on the table for one day. (Chapter XIV, Section 1, of By-Laws.)

The House of Delegates may amend any article of the Constitution by a *two-thirds vote of all the delegates present* at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session and that it shall have been published twice during the year in THE JOURNAL of the Association. Article XIV, Constitution.)

Any delegate who wishes to speak must rise and give his name and county to the reporter, and if he wishes to speak for any length of time he must come forward to the platform.

During the past year the following members of the Association who were members of the House of Delegates or who served the state association in an official capacity have died:

ROSCOE H. BEESON, Muncie. Secretary of Delaware-Blackford County Medical Society, 1921; vice-chairman of Medical Section, 1922; chairman of Medical Section, 1929; member of Committee on Diphtheria Prevention, 1932; Committee on Graduate Education, 1936; Committee on Study of Health Insurance, 1937 and

- 1938; and Committee on Public Relations, 1939 and 1940.
- PERRY C. BENTLE, Greensburg. Secretary of Decatur County Medical Society, 1911, 1912 and 1917; and member of Committee on Credentials, 1919.
- E. H. BRUBAKER, Flora. Secretary of Carroll County Medical Society, 1928 and 1930 to 1938 inclusive; member of Registration Committee, 1933; and Committee on Secretaries' Conference, 1934 and 1935.
- A. E. BURKHARDT, Tipton. Secretary of Tipton County Medical Society, 1918.
- WILLIAM F. CLEVINGER, Indianapolis. Member of Committee on Arrangements, 1910-1911.
- HUGH A. COWING, Muncie. Chairman of Committee on State Medicine, 1910-1911; Member of Committee to Study the Problem of Criminal Abortion, Its Increasing Prevalence, and to Recommend Ways and Means for Arousing the Public Conscience upon this Question, 1914-1915; and Committee on Arrangements, 1922.
- JAMES A. CRAIG, Greenwood. Member of Committee on Health Problems in Education, 1921.
- RICHARD B. DUGDALE, South Bend. Member of Committee on Public Policy and Legislation, 1909-1910; Secretary of St. Joseph County Medical Society, 1917 to 1933 inclusive; member of Committee on Arrangements, 1920.
- SIDNEY J. EICHEL, Evansville. Member of Committee on Arrangements, 1917.
- REUBEN F. FROST, Huntington. Member of Committee on Health and Public Instruction, 1914-1915.
- JOHN A. GIBBONS, Mitchell. Member of Committee on Tuberculosis, 1908-1909.
- CHARLES S. GOAR, Indianapolis. Member of Committee on Arrangements, 1910-1911, and 1924.
- PAUL C. GRAHAM, Columbus. Secretary of Bartholomew County Medical Society, 1911 and 1912; member of Committee on Conservation of Vision and Hearing, 1916.
- ANGUS C. McDONALD, Warsaw. Councilor for Thirteenth District, 1911-1917; President of the Indiana State Medical Association, 1930; member of Executive Committee, 1930; and member of Committee on Budget, 1931.
- GEORGE F. SMITH, Lawrenceburg. Member of Committee on Control of Cancer, 1939 and 1940.
- O. C. STEPHENS, Evansville. Secretary of Vanderburgh County Medical Society, 1925 and 1926.
- GERALD H. STONER, Valparaiso. Secretary of Porter County Medical Society, 1915 and 1919.
- BASIL M. TAYLOR, Portland. Secretary of Jay County Medical Society, 1929 to the time of his death in 1944; member of Committee on Diphtheria Prevention, 1936; Committee on Secretaries' Conference, 1937; and delegate from Jay County, 1934 and 1935.
- JAMES H. TAYLOR, Indianapolis. Member of Committee on Credentials, 1918; and Committee on Arrangements, 1924.
- WILLIAM H. WILLIAMS, Lebanon. Councilor of the Ninth District, 1911-1913; and member of Committee on Credentials, 1932.
- THOMAS M. JONES, Anderson. First Vice-president, 1922.
- D. L. MCAULIFFE, North Vernon. Secretary of Jennings County Medical Society, 1919 to 1944.
- H. C. METCALF, Connersville. Member of Committee on Public Policy and Legislation, 1940; member of Committee on Control of Cancer, 1944; delegate from Fayette-Franklin County Medical Society, 1939 through 1942.
- O. O. MELTON, Lowell. Member of Committee on Industrial and Civic Relations, 1920.
- E. T. ZARING, Terre Haute. Vice-chairman of Section on Anesthesia, 1939; and Chairman of Section on Anesthesia, 1940.
- In addition to the above the following have died in service:
- LIEUTENANT JOHN FRANCIS KERR, JR., Indianapolis, August 18, 1942.
- LIEUTENANT EMIL NICHOLAS KVETON, M.C., U.S. N.R., killed in action at sea, August 9, 1942.
- COLONEL FRANK BOLLES WAKEMAN, M.C., U.S.A., Washington, D.C., formerly of Valparaiso, March 17, 1944.
- CAPTAIN JOHN ELLIOTT CARTER, M.R.C., U.S.A., Richmond, died in service in the Southwest Pacific, July 22, 1943.
- LIEUTENANT KURT BENJAMIN KLEE, M.R.C., U.S.A., Indianapolis, killed in action in North African area, July 10, 1943.
- CAPTAIN ROBERT C. BADERTSCHER, Bloomington, died in an Army bomber crash at Iquito, Peru, South America, September, 1943.
- CAPTAIN HARRY D. MILLER, M.C., U.S.A., Shelbyville, killed in an accident in Algeria, February 2, 1944.
- LIEUTENANT COMMANDER MARTLIN P. SMITH, M.C., Muncie, killed in an automobile accident in North Africa, July 5, 1944.
- (The members stood for one minute in silent tribute to these departed members.)
- (On motion of Dr. George R. Daniels, the minutes of the previous meetings, as printed in THE JOURNAL, were accepted.)
- THE PRESIDENT: Article V of the Constitution gives the delegates to the American Medical Association the right to sit in the House of Delegates and have the privilege of the floor, but no power to vote. This has been interpreted to include alternates. These delegates and alternates are:
- | <i>Delegates</i> | <i>Alternates</i> |
|-------------------------------|-----------------------------|
| H. G. Hamer, Indianapolis | J. E. Ferrell, Fortville |
| George Dillinger, French Lick | A. S. Giordano, South Bend |
| Don F. Cameron, Fort Wayne | N. M. Beatty, Indianapolis |
| F. S. Crockett, Lafayette | A. M. Mitchell, Terre Haute |

All members of the Association who desire to sit in on this meeting to hear the deliberations of the House are welcome.

In accordance with Chapter IX, Section 1, of the By-Laws of the Association, reference committees have been appointed and the names of the members of these committees were published in the September JOURNAL and in the *Handbook*. These committees are to serve during the session at which they are appointed.

These reference committees should not be confused with the all-year-round standing committees. To these committees shall be referred all reports, resolutions, and measures presented to the House of Delegates at this session, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted at the next meeting of the House of Delegates for acceptance in the original or modified form, or for rejection. Unless decided differently, the next meeting of the House of Delegates will be held at 7:15 Thursday morning, October 5 (breakfast meeting), in the Riley Room, mezzanine floor, Claypool Hotel.

Each committee will consist of five members, the first member named to be the chairman of the committee.

Because of the importance of the subject matter, the chair is appointing this year a special reference committee on the State Board of Health program, including the postwar program. All resolutions and statements in regard to this subject will be referred to this special reference committee. This committee, if it so desires, may hold its meetings in the committee room back of the registration desk, first floor, Murat Temple. All those having questions in regard to this subject of the care of servicemen's families, or matters having to do with the State Board of Health, may contact this reference committee and the Advisory Committee to the Bureau of Maternal and Child-Health of the Indiana State Board of Health, in charge of the EMIC program.

Since this will be one of the most important meetings of the House of Delegates held up to this time, I want to impress upon the members of the reference committees the importance of their attending the committee meetings, studying these reports, and bringing in reports which the House may act upon. As I call the names of these reference committees, I want you to stand until the committee is completed. I wish you would identify each other, and at the close of this meeting your chairman will find out here at this desk the place of meeting of each committee.

MR. HENDRICKS: Arrangements have been made for special rooms for the committees behind the registration desk.

REFERENCE COMMITTEES

1944

I. SECTIONS AND SECTION WORK:

Chairman, Minor Miller, Evansville (Vanderburgh)
O. G. Brubaker, North Manchester (Wabash)
Morris Balla, South Bend (St. Joseph)
V. L. Turley, Fowler (Benton)
O. H. Stewart, Aurora (Dearborn)

2. RULES AND ORDER OF BUSINESS:

Chairman, Charles N. Combs, Terre Haute (Vigo)
Earl Van Reed, Lafayette (Tippecanoe)
W. U. Kennedy, New Castle (Henry)
Carl Clark, Oakland City (Gibson)
J. F. Maurer, Brazil (Clay)

3. MEDICAL EDUCATION AND HOSPITALS:

Chairman, Ernest Rupel, Indianapolis (Marion)
G. V. Cring, Portland (Jay)
Gordon A. Thomas, Lafayette (Tippecanoe)
Harold Ochsner, Indianapolis (Marion)
E. P. Buckley, Jeffersonville (Clark)

4. PUBLIC POLICY AND LEGISLATION:

Chairman, Jesse E. Ferrell, Fortville (Hancock)
A. A. Thompson, Tyner (Marshall)
J. O. Ritchey, Indianapolis (Marion)
Alfred Ellison, South Bend (St. Joseph)
H. W. Eggers, Hammond (Lake)

5. PUBLICITY:

Chairman, Rollin Moser, Indianapolis (Marion)
John H. Barrow, Dale (Spencer)
F. R. N. Carter, South Bend (St. Joseph)
Paul A. Garber, South Whitley (Whitley)
Jon Kelly, LaPorte (LaPorte)

6. HYGIENE AND PUBLIC HEALTH:

Chairman, Goethe Link, Indianapolis (Marion)
C. C. Atkins, Rushville (Rush)
W. D. Inlow, Shelbyville (Shelby)
W. H. Lane, Angola (Steuben)
P. Q. Row, Hammond (Lake)

7. AMENDMENTS TO CONSTITUTION AND BY-LAWS:

Chairman, George R. Daniels, Marion (Grant)
W. C. Wright, Fort Wayne (Allen)
F. M. Lynn, Peru (Miami)
B. W. Egan, Logansport (Cass)
I. M. Sanders, Greensburg (Decatur)

8. REPORTS OF OFFICERS:

Chairman, C. S. Black, Warren (Huntington)
Clay Ball, Muncie (Delaware)
George J. Garceau, Indianapolis (Marion)
E. O. Nay, Terre Haute (Vigo)
J. R. Crowder, Sullivan (Sullivan)

9. COMMITTEE ON CREDENTIALS:

Chairman, S. M. Cotton, Goldsmith (Tipton)
A. E. Stinson, Rochester (Fulton)
Ralph J. Harvey, Zionsville (Boone)
Max R. Adams, Flora (Carroll)
G. S. Fessler, Rising Sun (Ohio)

10. COMMITTEE ON MISCELLANEOUS BUSINESS:

Chairman, M. C. Topping, Terre Haute (Vigo)
J. C. Elliott, Guilford (Dearborn)
N. A. James, Tell City (Perry)
Paul J. Blessinger, Jasper (Dubois)
M. R. Lohman, Fort Wayne (Allen)

11. SPECIAL COMMITTEE ON STATE BOARD OF HEALTH PROGRAM:

Chairman, Harry P. Ross, Richmond (Wayne)
E. R. Clarke, Kokomo (Howard)
C. M. Donahue, Carmel (Hamilton)
Naomi Dalton, Bloomington (Monroe)
W. A. Thompson, Liberty (Union)

12. SPECIAL COMMITTEE ON HEALTH INSURANCE:

Chairman, F. S. Crockett, Lafayette (Tippecanoe)
C. B. Paynter, Salem (Washington)
J. H. Weinstein, Terre Haute (Vigo)
T. Z. Ball, Crawfordsville (Montgomery)
W. L. Portteus, Franklin (Johnson)

THE PRESIDENT: The reports of officers, except the President's Address, which is to be given tomorrow morning, were printed in the September JOURNAL and the *Handbook*. I have no special report to make at this time, but I would like to urge each member of these reference committees to make it his business to attend the committee meetings and study the reports turned in.

I would now like to introduce the President-elect, Doctor N. K. Forster, of Hammond, who will address us.

ADDRESS OF THE PRESIDENT-ELECT

DR. N. K. FORSTER:

Mr. President and Members of the House of Delegates of the Indiana State Medical Association:

During the past year it has been my distinguished privilege to be associated with the officers of our association in the conduct of its business matters and in the handling of the problems that have come before them. This period of initiation into the machine shop of the organization has been both pleasant and instructive, and has left me with a great feeling of pride as I witnessed the intense and earnest manner with which the many and varied situations were met and settled. That this required the combined and unselfish efforts of Doctor Oliphant, Mr. Hendricks, your Executive Committee, the Council, and numerous committees meeting with them, reflects all the more the splendid spirit of cooperation, and, what is most important, the desire and willingness of these men to sacrifice their own time, in these hectic days, to accomplish the things that make for a better organization.

This experience has, however, left me with a deep sense of my own inadequacy to measure up to the distinguished records of accomplishment of the men who have preceded me. My apprehension must be balanced by the knowledge that we are all engaged in a common effort, that your interests are my interests, and that however divergent may be our methods of approach, the solution of our problems will be met by understanding and cooperation. In such manner the achievements of the past become the assurances for the future.

With this premise in mind there are a few recommendations I should like to place before you for your consideration and action. These have to do with the formation of some new committees whose functions will consist in study and recommendations for action along their specific lines.

(1) Many state associations, as well as county societies, have appointed postwar planning committees to consider measures to assist members in the armed forces in adjusting themselves to civilian practice upon their discharge. These plans have taken the form of available funds for loans, provision of office space, part-time assistantship, post-graduate education, relocation information, and other suggestions. While it is realized that these questions ultimately devolve upon local county so-

cieties for their administration, nevertheless it seems apparent that state organizations must not only be active in promoting measures, devising plans and setting up programs, but actually active in their initiation and fruition. Indiana will not be aloof in the helpful solution of many problems that are bound to confront our colleagues upon their return, and I should like to urge the creation of a Committee on Postwar Medical Service to study these problems and provide a working basis for actual functioning and assistance.

(2) Many of you have followed the recent conferences in Washington leading to the creation of a National Committee on Physical Fitness. The necessity for this step has been forcefully brought out in the large number of rejections at Selective Service induction centers because of physical defects. The uncovering of the mental and physical defects of our younger population has been promptly seized upon by the proponents of compulsory health insurance and government-controlled medical practice as an additional argument for the necessity of such measures.

In spite of the fact that a breakdown of the statistics reveals that 80 to 85 percent of the defects causing rejection were not amenable to medical or surgical treatment, and that they were due to poor heredity, malnutrition, bad environment, neglect of teeth, fractures, deformities, and other conditions correctable in early life, we are, nevertheless, placed in the position of having bitter criticism laid on our doorstep. We are aware of the fact that no amount of medical care or its adequate distribution can combat the effects of ignorance, indifference, poor nutrition, inadequate sanitation and bad housing; and we know that such arguments that governmental-controlled clinics would have prevented such widespread physical disability has no basis in fact. Nevertheless, we must cooperate in such measures that directly affect our activities, and assume our responsibilities in the correction of such defects as may properly be a part of medical function.

The program to which this National Committee will address its activities will consist of an evaluation of the physical state of young men and women; increasing the activities and responsibilities of schools and colleges in physical education; improving the opportunities for gaining physical health; and enlisting the active support of industrial, social, religious, patriotic, professional and other groups.

In view of this movement I would like to suggest, therefore, that our present State Committee on the Study of High School Athletics be discontinued, and that in its place a new Committee on Physical Fitness be formed whose efforts will be directed toward cooperation with the parent committee of the American Medical Association in its activities and study of such problems, and in recommending to the state organization programs aimed at the prevention of physical unfitness and the rehabilitation of the physically unfit.

(3) During the past year you have been presented with the results of a long and thorough study by Dr. C. A. Nafe and the members of the Executive Committee in the adoption of a group policy covering medical practice liability. The policy chosen represents not only an advance in securing greater limits of coverage but, what is more gratifying, an adequate reduction in cost, on a group basis, for similar coverage. Not only does this step relieve the individual of anxiety in his dealings with the public, but it also relieves the association of some part of its medical defense costs. In addition, we have the assurance that, "if experience under the group defense arrangement justifies it," we will ultimately secure a further reduction in the cost of this type of insurance.

It seems to me that this represents a very important forward step in our economics, and demonstrates what may be accomplished when we are united and cooperate in matters of our utmost concern. There are many other items affecting our economy which might well be studied, and the results of such studies presented to our organization for action. To mention a few:

The question of a group health and accident policy.

The informative study on questions of life insurance, annuities, public liability and property damage insurance, automobile insurance, and related problems.

The problem and solution of situations affecting the aged or needy physician.

The questions arising with reference to tax problems and the release of informative material relative to rules and regulations affecting them.

The issues involving location or relocation of physicians.

The inquiry into all such related matters as may affect the medical economics of our profession and the recommendations that may be deduced from such studies.

These represent an enormous territory of unexplored problems from the standpoint of active participation by our organization, and it is obvious that no committee at present is composed to carry out its manifold implications. Nor can any one committee consider all of its involved problems at any one time. However, a start has already been made in the provision of our group medical practice liability policy, and it is not an impossible task to go on from there. Therefore, I should like to recommend the creation of a committee on Medical Economics whose function it will be to consider and report on these various problems.

(4) The creation by the American Medical Association of its Council on Medical Service and Public Relations, and the approval of the House of Delegates of its revised platform, has indicated the necessity for participation by state and county organizations in cooperative efforts to derive the highest dividends from its operation. It is unnecessary to review the reasons and events which have

prompted the institution of this Council. The political and social unrest prevalent throughout the country indicates too well that the medical profession cannot be set aside as a distinct and separate entity. The affairs of the country, as well as the changes contemplated or in force in our government, affect us in a similar manner as they affect all groups or individuals. The demand for better medical public relations, heard all over the country, springs from a belated recognition of the fact that in a world of high-powered propaganda it is necessary to seem right as well as to be right. It is correct to say that no other group can match medicine's record of devoted service to the public good. Yet, today, even in the field of healing, other voices take precedence over the doctors'. The reason, of course, is that physicians have been too preoccupied with extending and applying their professional knowledge to explain the why and wherefore of their activities to the public. To all too many laymen such potent diagnostic and therapeutic media as the x-ray, the electrocardiogram, the sulfonamides, and penicillin are wonders wholly apart from the physicians who employ them, and without whom they would be useless or even dangerous instrumentalities.

This tendency to "play down" the doctor is even more marked in the field of medical economics, where pressure groups ignore and distort history to depict the profession as selfish and shortsighted. Clearly, it is necessary for us to address ourselves not only to fellow members in our profession but also to the citizens of the communities whose welfare is closely knit to our everyday life and activities. Because of the exigencies of wartime we have been taking patients for granted, but the time is nearly here when patients can no longer be taken for granted. That is going to come as quite a jolt to a lot of people, and the harder the jolt, the better for the profession. If we are wise, we can prepare for such situations. As important as public relations experts are in achieving more effective public relations, they do not relieve us, as individual practitioners, of the duty to carry on our own private campaign. You and I are medicine's public relations men, so far as our patients are concerned. If they show interest in medical, social, and economic issues, be prepared and take the time to explain medicine's attitude to them. Show them their stake in the maintenance of the existing system of medical practice. As we exemplify, in word and deed, the best traditions of medical science and ethics, so will we lay the foundation that no amount of adverse propaganda can alter the picture our patients know to be true.

Therefore, may I suggest the creation, by this House of Delegates, of a Bureau of Medical Service and Public Relations to cooperate, in all ways possible, with the Council of the American Medical Association. This Bureau should be composed of the chairmen of our committees on Public Policy and Legislation, Bureau of Publicity, Public Relations, Permanent Study Committee on Health In-

surance, Civic and Industrial Relations, Medical Economics, the members of the Executive Committee, the Editor of *THE JOURNAL*, and the Executive Secretary.

The formation of such a group complies with the wishes of the American Medical Association in seeking such cooperative measures on a state level, and, it is to be hoped, will assist the aims of the Council of the American Medical Association and the purposes for which it was created. In this same connection I am hopeful that one of the first acts of this bureau will be the formation of a Council on Public Health, similar to those created in California and Michigan, composed of representatives of the medical profession, the dental profession, the hospital association, the pharmacists, the nursing profession, the insurance groups, and interested civic groups. The function of this council should be the ascertaining of the public reaction to problems of health, and the best measures for distributing medical care to all the people. Believe me, we need the assistance of all of our allies in the stormy days ahead.

There is a trite and hackneyed phrase that pictures medicine at the "crossroads." Ever since I can remember, this phrase has been employed to indicate some pressing problem or situation which was likely to upset the existing, orderly progress of medicine. Fortunately, these have proved to be mostly forks in the road, and medicine has pursued its course unflinching. It must be evident to all of us, however, that the settled complacency of our profession is due for an overhauling. The opponents of free medical practice intentionally have made American Medicine appear confused and lacking in breadth of vision. The proponents of the socialization of medicine are continuously at work, devising new plans and measures to accomplish their purpose. Failure in one project becomes the incentive for a new procedure. The sleeping Wagner-Murray-Dingell Bill proved too large a chunk to bite off at one time, so we have witnessed the EMIC plan put into effect under the pressure of wartime emergencies. That it is intentionally designed to bring about the socialization of medicine is evident in its gradual broadening of the list of conditions eligible for treatment, and the fact that it has consistently scorned medical opinion in formulating and directing its medical projects, and fills its so-called "educational literature" with unadulterated propaganda.

A new bill is now designed to place the problems of industrial hygiene and health within the province of the Department of Labor, thus giving lay labor departments complete domination of industrial hygiene. As in other instances, early hearings on this legislation were conducted in secrecy, and no interested public health or medical groups were notified until their conclusion.

Surgeon General Parran is now advocating a two-billion dollar public health program. The plan calls for supplying 417,000 hospital beds and 2,400 health centers and sub-centers, and does not include pro-

visions for the health needs of veterans which, he indicates, "the nation must place on a sound basis." The implications are that the present plan of American medical and hospital practice has been a failure, and his statement that "too much heat and not enough light" has been turned on socialized medicine indicates the trend of his thinking.

The venereal-disease program has resulted in the strange situation where a case of this character has now become a rarity in the hands of the general practitioner and specialist alike. Public Health clinics have assumed the role of extensive and successful competitors in this field of medical practice.

' But why go on with this recitation—you know it all too well. The planned maneuvers of the bureaucrats and the socialistically-minded are based on pincer movements to engulf, one after another, the various fields of free medical practice. Divide and conquer is their avowed intention in their determination to win control of medical practice and public health. Their forces have now assumed such tidal proportions that it seems inevitable that changes in our medical system are now impending. What can be done to influence the course and direction these changes may take? Two things present themselves. We may provide such a system of plans for development and distribution of medical service that governmental intervention becomes unnecessary. We may, on the other hand, adopt a unified, aggressive stand that refuses to accept the interference of governmental dictation in medical matters. No other avenues appear open. The roads of compromise are blocked. The detours of delay are closed. The paths of procrastination are obstructed. Which course will we pursue? It is up to us. May we think and act straight. The future of American Medicine for many years to come depends upon our course.

"When God made the oyster, He guaranteed him absolute economic and social security. He built the oyster a house, his shell to protect him from his enemies. When hungry, the oyster simply opens up his shell and the food rushes in.

"But when God made the eagle, He said, 'The blue sky is the limit. Go build your own house.' And the eagle went out and built his house on the highest mountain crag, where storms threaten him every day. For food he flies through miles of rain and wind.

"The eagle, not the oyster, is the emblem of America."

Referred to the Reference Committee on Reports of Officers.

REPORT OF EXECUTIVE SECRETARY

Referred to the Reference Committee on Reports of Officers.

REPORT OF TREASURER

Referred to the Reference Committee on Reports of Officers.

REPORT OF CHAIRMAN OF COUNCIL

DR. F. T. ROMBERGER, chairman: *Mr. Chairman, Members of the House of Delegates:* In addition to

the Report of the Chairman of the Council, as printed on page eighteen of the *Handbook*, the following action was taken at the Council meeting at twelve-thirty today. The following motion, made by Doctor Wadsworth, was adopted:

"I move that the Council recommend to the House of Delegates a war assessment of \$5.00 per member per year, beginning January 1, 1945, for the duration of the war and one year thereafter."

In explanation, I would like to say this: A year ago the Council was authorized by this House of Delegates to make certain changes and additions to supplement the work in the headquarters' office. Following and ensuing and in accordance with the directions of this House of Delegates, your Council has carried out those orders. Thus, owing to many factors beyond our control, the treasury of our state association has been slightly depleted. The monies in our association treasury belong not only to us but also to our doctors who are in service. We feel that these monies should be used for the best interests of those who will practice medicine ten, fifteen, twenty years hence, and the Council therefore is of the opinion that the treasury should be reimbursed for this shortage and be placed in a position where we can carry on the best interests of the medical profession in the State of Indiana.

Referred to the Reference Committee on Reports of Officers.

REPORTS OF STANDING AND SPECIAL COMMITTEES

COMMITTEE ON CREDENTIALS

Referred to the Reference Committee on Credentials.

EXECUTIVE COMMITTEE

DR. CLEON A. NAFE, chairman: Our report has been published, and those who have read the well-edited *JOURNAL* have had a review of our activities, but I have been asked by the committee and by the president to discuss a question that has arisen in the minds of various members, not only today but at other times, and that is the subject of group malpractice insurance. We consider it advisable to take it up at this time because of questions that have come to the headquarters office. There seems to be a lack of understanding on the part of the profession, which would imply that you had not read *THE JOURNAL* well, because most of the questions asked have been covered in it. The reaction has been very good throughout the state, but several doctors have written in asking questions, as follows: "What right has the state association to tell us from whom we shall buy insurance?" "Should I drop the insurance I already have?" "Does the association pay for this?" "Does this affect the protection given by the state association?"

In the first place, you will recall that at the meeting of the House of Delegates in 1943 the committee made a supplementary report in which we set out the experience of other state associations,

and asked if you wished us to do anything about it. It had previously been discussed twice at the Council. At that time you were told that this plan would not be successful unless a majority of the doctors took out this insurance. At that time we not only received no dissenting voice, but we were instructed by the House of Delegates to proceed with such plans and secure a contract. Therefore, we proceeded on that basis. The association does not pay for this, and this in no way affects the protection given by the association. We advise that you secure this insurance contract when your present contract expires.

We became interested in this problem because numerous complaints concerning their malpractice insurance had come before the Executive Committee during the last five years. These complaints may be classified in three groups: First, malpractice rates have increased, more in some regions of the state than in others, and upon facts and figures available to us we were unable to justify these increases. The figures of the insurance companies were not available, and we found that there were no uniform rates for the different companies, nor for the state as a whole. Second, one company selling a large number of these policies advised the physicians that \$5,000 was sufficient coverage, and physicians complained that that company would not sell more protection, stating that a larger coverage encouraged larger suits. We believe that this is a misstatement of fact, because it is well-known that courts have always ruled that the question of insurance coverage cannot in any way be introduced before the jury as evidence in any damage or liability suit. Our attorney advised us that \$10,000 is a reasonable figure for minimum coverage because that is the amount usually allowed by courts in any death claim arising from liability suits of any kind. Third, three suits in Marion County alone, against doctors for damages for legal acts properly carried out by the physicians in which malpractice was not specifically charged, were not defended by one company. The Executive Committee felt that two of these should have been defended, and that the third should properly have been covered by a policy of this sort. Other cases have occurred throughout the state. The Executive Committee had a feeling that in recent years insurance companies had been making a narrower interpretation of their contracts, and had an actuarial study made of the contracts of all companies doing business in this field in Indiana. The final interpretation of that study was that the extent of coverage was practically the same of all these companies, but there were types of cases which these contracts did not cover.

After we were instructed about this matter we wrote to companies interested in doing this kind of insurance in this state. Of the nine that were writing malpractice insurance, only four were interested in writing a group policy covering the entire state. The Fort Wayne Company was not interested in group insurance. The United States

Fidelity and Guaranty Company said that it was not interested. We told each of them that we felt that the doctors of Indiana wanted three things: first, complete coverage, coverage that would protect them from damage suits arising as a result of the legitimate acts and duties of the practice of medicine; second, adequate coverage—we recommended \$10,000-\$30,000 as a minimum, with the doctor having option to buy larger or smaller amounts of coverage as he desires; third, we felt that the doctors were willing to pay the cost, provided the Executive Committee would have the right to review the experience of that company, and that rates would be adjusted downward as soon as experience justified that reduction. Along that line, I talked to the Insurance Commissioner of the State of Indiana with reference to how the malpractice rates were determined, and he told me that there was no way of arriving at that rate, as there is in the case of fire, automobile, theft, and liabilities of that type. He personally approved of the idea of all physicians securing insurance in a selected company, stating that from such a broad base and experience a just rate could be determined, as is done in all compensation insurance with various companies at the present time. However, after considerable study of this problem, and various conferences with company representatives, we secured a group contract with the St. Paul Mercury Indemnity Company, which is a subsidiary of the St. Paul Fire and Marine Insurance Company, an old and established company. We have been asked why we selected this company. We selected it primarily because we felt that this company would give us the best coverage, and would cooperate to the fullest extent. For the last eight or nine years that company has been in the field of hospital insurance in cooperation with the American Hospital Association and the American College of Surgeons. I talked to Doctor MacEachern and Doctor Williams, of the American College of Surgeons, and they said that they had been working with this company in hospital insurance, and gave it a fine recommendation. This company has made extensive studies and surveys in regard to hospital insurance, and now carries complete insurance on a large percentage of the hospitals approved by the American College of Surgeons. This insurance carries a group policy for members of the staff. Don Hawkins, vice-president of this company, is insurance consultant to the American College of Surgeons and the American Hospital Association. All inquiries have revealed that it is a very fine company, and is particularly interested in this field.

I would like to mention one more thing, and that is that there has been a letter received by most of you from the Medical Protective Company, of Fort Wayne, and I will say that our experience with that concern has always been pleasant. But the Medical Protective Company does not believe in this type of coverage, and has sent out a letter which we think misrepresents the situation. This letter indicates that an insurance organization

under the group plan in one state—it does not say what state—cost the doctors of that state \$800,000 to \$1,000,000 more than their insurance in a similar state. Our conversations with other state associations do not in any way substantiate that statement. Doctor McCaskey, Mr. Hendricks, and myself have talked to the state secretaries of Connecticut and Oklahoma. In Connecticut, by a group policy with the Aetna, rates which were very high were reduced to less than twenty dollars for \$15,000-\$30,000 coverage. In Oklahoma a bad situation existed and rates rose so that they were paying approximately seventy-five dollars for \$10,000 coverage, and in two or three years it was cut in half by a group contract with the London and Lancashire, and the secretary was quite enthusiastic about the plan.

Already sixteen states have group malpractice insurance. In some states large county societies have group coverage. Several other states are now considering such a coverage with a good company.

In submitting this report I want to urge, as I did last year, that this group policy be supported by the doctors. This will be successful in direct proportion to the support given by the physician, since a broad base is needed to stabilize the cost. This company happens to be our choice because we thought it was the best, one that can guarantee complete coverage, and that is the only way we will be able to make a good study of the cost of malpractice insurance. I assure you that we have no personal interest in this whatsoever. You can buy the policy from your own representative in the community. There are two here in Indianapolis, and many other agents throughout the state. We really think that this is an important step. We have dealt with this problem for some time, and ask that you support it.

DR. GORDON THOMAS: Are there any basic rates in effect?

DOCTOR NAFE: Twenty-five dollars for \$5,000 and \$15,000 limits; thirty-one dollars for \$10,000 and \$30,000 limits; and if you are doing x-ray therapy the premium is doubled for those limits, making it fifty and sixty-two dollars, respectively.

THE PRESIDENT: All of Doctor Nafe's report, except the paragraph regarding the State Board of Health, will be referred to the Reference Committee on Reports of Officers. The paragraph regarding the State Board of Health will be referred to the Reference Committee on State Board of Health.

COMMITTEE ON ARRANGEMENTS

Referred to the Reference Committee on Miscellaneous Business.

COMMITTEE ON SCIENTIFIC WORK

Referred to the Reference Committee on Sections and Section Work.

REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. NORMAN BEATTY, co-chairman: In addition to the published report in the *Handbook*, the committee wishes to make the following supplementary report:

Owing to the fact that the State Board of Medical Registration and Examination provides for its members to be representatives of special schools of medicine, the graduates of which were numerous at the time the board was first organized but are few in number now, it is necessary that the law be changed so that these places on the board may be filled by any Doctor of Medicine holding an unlimited license.

Your committee recommends that the House of Delegates instruct the Committee on Public Policy and Legislation to use its best efforts to encourage the passage of such legislation designed to make this change. The attorney for the association has prepared the following bill which will accomplish this purpose, and is as follows:

A BILL for an Act in regard to the State Board of Medical Registration and Examination, abolishing the said Board, and creating the Board of Medical Registration and Examination of Indiana and Prescribing its Duties.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF INDIANA, That the State Board of Medical Registration and Examination is hereby abolished and all the rights, powers and duties heretofore conferred by law upon said State Board of Medical Registration and Examination are continued in full force and effect and are hereby transferred to and conferred upon the Board of Medical Registration and Examination of Indiana hereby created. Any investigation, proceeding, hearing or examination, or any proceedings in any courts undertaken, commenced or instituted by or before the taking effect of this Act may be conducted and continued to a final determination by the Board of Medical Registration and Examination of Indiana hereby created, in the same manner and with the same effect as if this Act had not been passed; all existing contractual and other rights, legal or equitable, of, or created by, any act of the State Board of Medical Registration and Examination are hereby saved and continued and transferred to the Board of Medical Registration and Examination of Indiana which is hereby created; all existing appropriations for and all funds held by the State Board of Medical Registration and Examination are hereby continued and transferred to and shall stand to the credit of the Board of Medical Registration and Examination of Indiana which is hereby created. Nothing in this Act shall be construed so as to repeal any part of any Act or Acts under authority of which the State Board of Medical Registration and Examination

was created, or of any Act amendatory or supplemental thereto conferring any power or duty upon the State Board of Medical Registration and Examination, except such as are in direct conflict herewith, it being the intent of this Act to substitute the Board of Medical Registration and Examination of Indiana hereby created for the State Board of Medical Registration and Examination in the performance of all the duties heretofore conferred by law upon the State Board of Medical Registration and Examination.

SECTION 2. The Board of Medical Registration and Examination of Indiana is hereby created. It shall consist of seven (7) members, not more than four (4) of whom shall be members of the same political party. The members shall be appointed by the Governor, and all vacancies occurring on such Board shall be filled by the Governor. Immediately upon the taking effect of this Act the Governor shall make the following appointments to such Board:

(a) Five (5) reputable physicians who are graduates of recognized medical colleges with the degree of Doctor of Medicine and hold unlimited licenses to practice medicine in the State of Indiana, two (2) of which appointees shall serve for one year, one (1) for two years, one (1) for three years, and one (1) for four years; and their successors shall serve for terms of four years each.

(b) One (1) reputable osteopathic physician who shall be a graduate of a recognized school or college of osteopathy with the degree of Doctor of Osteopathy, licensed to practice osteopathy in the State of Indiana, who shall serve for a term of four years.

(c) One (1) reputable practitioner of that system or method of healing not represented under (a) and (b) above which has the largest numerical representation of practitioners or members in the state, who shall be a graduate of a school or college teaching said system or method and licensed to practice it in the State of Indiana; who shall serve for a term of four years.

SECTION 3. Immediately following the appointment of the members of the Board of Medical Registration and Examination of Indiana they shall meet and organize in the manner in which the State Board of Medical Registration and Examination has heretofore been organized, and take over and continue the functions, powers and duties heretofore conferred by law upon the State Board of Medical Registration and Examination.

In brief, the story is this: In 1890, when the Act was first passed, the members of the State Board of Medical Registration were specifically required to be graduates of schools—physio-medical, eclectic, homeopathic, and allopathic. But as time has gone on, some of these schools are no longer in existence, and the number of persons who are

eligible under this classification is exceedingly small. It was foreseen, both by the members of the board, by your attorney, Mr. Stump, and by the committee that soon it will be practically impossible to find men who would come under this classification. The entire purpose of this bill will be to make it possible for any physician holding an unlimited license to practice medicine to be eligible for these various appointments. The number of the members will not be changed; it will be the same number.

I would like to say one word in connection with the supplementary report. I believe that the election during the coming month will be one of the most important elections we have ever faced as a profession, or ever will face. Every county society has been sent bulletins from the headquarters office, and should be ready to contact the candidates. We have heard from some of the societies, but a few we have not heard from. A few weeks ago our committee held an all-day meeting here in the city, to which we invited representatives from every county society. We had Dr. Joseph Lawrence, the American Medical Association representative in Washington, who is acquainted with what the American Medical Association is doing down there. We are trying to bring about a better understanding on the part of these representatives, both in Congress and in the legislature. I was told that in Cass County the doctors had a dinner to which they invited all the candidates for the legislature. When a measure is presented for their consideration these men will remember that there is somebody back home interested in what they do. Some of the larger counties have made contact with these candidates; some of them, including our own, have not. The time is short; we have only a month left. What we can do with the legislature is your responsibility in carrying out the wishes and instructions from this House of Delegates.

Referred to the Reference Committee on Public Policy and Legislation.

BUREAU OF PUBLICITY

DR. H. G. HAMER, chairman: I have no additions or comments to make on the annual report of the Bureau of Publicity, published in the last number of *THE JOURNAL*. The Indiana State Medical Association will soon reach its one hundredth year, having been organized June 11, 1849. The Bureau of Publicity desires to cooperate in preparation for the celebration of this event at the annual meeting five years from now. Knowing how long it takes to assemble historical data, the Bureau of Publicity suggests that a resolution be presented at this meeting (and I understand one will be presented) and committees appointed to compile information on "one hundred years of medicine in Indiana." It seems to me that it is not too early to start.

Referred to the Reference Committee on Publicity.

CIVIC AND INDUSTRIAL RELATIONS

Referred to Reference Committee on Public Policy and Legislation.

MEDICAL EDUCATION AND HOSPITALS

Referred to Reference Committee on Medical Education and Hospitals.

JOURNAL PUBLICATION COMMITTEE

Referred to Reference Committee on Reports of Officers.

SECRETARIES CONFERENCE

Referred to Reference Committee on Miscellaneous Business.

PERMANENT STUDY COMMITTEE ON HEALTH INSURANCE

Referred to Special Reference Committee on Health Insurance.

NECROLOGY AND HISTORY

Referred to Reference Committee on Miscellaneous Business.

STUDY OF HIGH SCHOOL ATHLETICS

Referred to Reference Committee on Hygiene and Public Health.

MENTAL HEALTH

Referred to Reference Committee on Hygiene and Public Health.

ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD-HEALTH OF THE INDIANA STATE BOARD OF HEALTH

DR. H. F. NOLTING, chairman. I have this supplementary report to submit:

House of Delegates,

Indiana State Medical Association.

Gentlemen:

A joint meeting of the members of the Indiana State Board of Health and the Advisory Committee was held May twenty-eighth of this year.

Present at the meeting were Dr. Herman M. Baker, president of the board; Drs. Ernest Rupel and E. M. Van Buskirk, board members; Dr. Thurman B. Rice, secretary of the board; Dr. R. E. Jewett, director of the Division of Maternal and Child-Health and member of the Advisory Committee.

The discussion and deliberations of this meeting are reported in considerable detail in the September issue of *THE JOURNAL* for those who are interested. I would refer you to this report, as it would be too lengthy and time-consuming to repeat at this time.

Several things, however, may bear repetition, such as the delay in payment for services rendered, and that of receiving additional compensation from patient, patient's family, or otherwise. The delay in making prompt payment is due to two factors. Doctor Jewett explained that in about fifty per cent of the cases it was due to the failure of the doctors to make a report or to their making it in such a manner that further clarifying correspondence becomes necessary in order to pass on the voucher for payment. It was also explained that the case load is so

tremendous that some delay is unavoidable, because of insufficient trained personnel.

In regard to the second matter mentioned, it was the consensus of opinion that specialists who ordinarily charge higher fees than the flat, minimum fee allowed should either accept these cases according to the rules prescribed, without additional cost to patient, or family, or refer them to some general practitioner who is willing to accept these cases under the EMIC plan, or that the person ordinarily eligible could assume responsibility for payment as a private patient and not make application for assistance to the Indiana State Board of Health.

The following is a statistical report of the EMIC program, through April 30, 1944, which I think will be of interest to you:

	Maternity Cases	Pediatric Cases	Total
Number of cases authorized	10,393	1,421	11,814
Number of cases completed and closed out.....	4,546	683	5,229
Cost of care for cases closed out	\$418,836.38	\$24,712.92	\$443,549.30
Average cost of care for cases closed out.....	92.13	36.18	.....
Combined average for both maternity and pediatric cases .....	.....	.....	84.82

The over-all response by Indiana physicians giving their services under the provisions of the M.C.H. program to servicemen's wives and children has been quite satisfactory. It is not to be construed, however, that our Indiana physicians as individuals nor as an association are in complete accord with this arrangement. There is no doubt, however, that this service so generously given has been an invaluable contribution to the morale of our armed forces in knowing that their families are being adequately cared for.

Recently, the American Academy of Pediatrics withdrew its support from the Children's Bureau of the Department of Labor. The A.A.P. charges, I quote:

"That the Children's Bureau of the Department of Labor is now an active factor in the practice of medicine, dictatorially regulating fees and conditions of practice on a Federal basis, were made last month by the American Academy of Pediatrics, as it withdrew its support from the bureau.

"Cited as a specific example was the administration of the EMIC program, with its payments made directly to physicians and hospitals. The A.A.P. held that the granting of cash allotments to servicemen's wives, who would in turn pay the doctors and hospitals "would be preferable since it would tend to preserve the patient-physician relationship.

"While the academy admitted that 'under an emergency war program' the present EMIC plan 'is the most feasible,' it charged that 'The intent of the bureau is to enter the practice of medicine when the war is over and to continue the EMIC program under some other guise.' It asserted further that the Children's Bureau planned 'a

free-to-all service with full-time salaried physicians, paid for directly from general taxes, and controlled and directed by a Federal bureau.'

"The A.A.P. executive board announced that 'the academy and the pediatricians of the United States must withdraw their support from the Children's Bureau and use their influence to place all health activities under the Public Health Service.'

"In Washington, Dr. Martha M. Eliot, assistant chief of the Children's Bureau, said the 'EMIC will disappear when the war is over.' She denied that the bureau plans to engage in post-war practice of medicine."

The Board of Health of our various states are also up in arms over the dictatorial policies of the Children's Bureau at Washington. I am informed by Doctor Jewett that all state M.C.H. directors as a body are opposed to the bureau's arbitrary methods of arriving at wholly inadequate fees and policies. They are this week organizing an association of state M.C.H. directors with the purpose of bringing about concerted effort in the shaping of policies and fees in keeping with the needs of individual states.

Before I close I wish to call your attention to a message released by the surgeons general of the Army and Navy in recognition of the valuable assistance given to the war effort by doctors who have served so faithfully and untiringly on the home front. Quote: "The morale in the armed forces is being raised and our fighting men go overseas with greater confidence in the security of their families because of this wartime program. Your contribution is an invaluable aid to us in the prosecution of the war, and we count on your carrying this program forward in the year to come with the same generous spirit you have shown in the past year."

To this we say, "Thank you, Vice Admiral Ross T. McIntire, Surgeon General of the Navy, and Major General Norman T. Kirk, Surgeon General."

The committee deeply appreciates the cooperation of Drs. R. E. Jewett and Thurman B. Rice, of the Indiana State Board of Health. We salute the doctors in all our armed forces, wherever they may be, and to the doctors back home in Indiana we say, "Thank you—well done."

H. F. NOLTING, *Chairman.*

To be referred to the Reference Committee on Public Policy and Legislation.

LIAISON COMMITTEE OF THE DIVISION OF SERVICES FOR CRIPPLED CHILDREN

Referred to the Reference Committee on Public Policy and Legislation.

AUDITING

Referred to the Council.

CONTROL OF CANCER

Referred to the Reference Committee on Hygiene and Public Health.

VENEREAL DISEASE

DR. E. O. NAY, chairman: I wish to submit this supplementary report in addition to the report of

the committee which has been printed in THE JOURNAL:

WHEREAS, it has been brought to the attention of the Venereal Disease Committee that there has been interference in the conduct of local venereal disease clinics on the part of district health departments; and

WHEREAS, these districts were originally a temporary set-up to help administer health matters following the 1937 flood; and

WHEREAS, the district units are clearing venereal disease matters primarily through the department of local health administration of the State Board of Health, and

WHEREAS, the acceptance of Federal funds and loans of United States Public Health Service personnel carries with it Federal domination; therefore the Venereal Disease Committee recommends:

1. That the district health units be abolished until such time as units may be set up in accordance with the present state law, and then be organized from the county level up to the state rather than from the state down.

2. That venereal disease matters be cleared through the State Department of Venereal Disease Control and not the Department of Local Health Administration.

3. That venereal disease control be financed by local units where possible, with state aid where necessary, but that Federal funds be refused.

4. That public health matters be administered in the State of Indiana without the aid of United States Public Health Service personnel except in the capacity of consultation on request, and on a temporary basis only.

5. That the Indiana delegates to the American Medical Association be instructed to present these recommendations to the next meeting of the House of Delegates of the American Medical Association to encourage other state delegates to get their state medical associations to take a similar stand.

Referred to the Reference Committee on Hygiene and Public Health.

INDUSTRIAL HEALTH

DR. E. S. JONES, chairman: In addition to the published report, we have this supplementary report to submit:

RELATIONSHIPS BETWEEN INDUSTRIAL AND PRIVATE PHYSICIANS

(Developed by the Committee on Industrial Health of the Lake County Medical Society, and approved by the Lake County (Indiana) Medical Society and the State Committee on Industrial Health.)

It is appreciated that no laws, rules or regulations can be made that will apply to all equally. No rules can displace common sense and good judgment. In order that we may more nearly approach the golden rule in the relation between industry, labor, and the medical profession, the following principles are submitted.

1. Pre-employment examinations.—It is recognized that the physical examination of applicants

for work is the prerogative of an employer; that the time and place of such examinations are matters within his jurisdiction; and that he must have free choice of the physician who is to make the examinations. The foregoing assumes that the employer pays the entire cost of the medical service rendered. The examining physician in this circumstance is performing a service for the employer, and has primarily the single obligation to further the employer's interest. It is recommended, however, that in the broader interest of the community he accept the following rules of practice:

(a) Make available to the personal physician of an examinee a full report of the latter's examination; this to hold only in the event an examinee requests that a report be made.

(b) Willingly consult with the examinee's personal physician when differences in opinion regarding medical findings exist.

(c) Refrain from naming a practitioner to whom the examinee should report for correction of defects discovered in the examination.

2. Occupational Diseases and Injuries.—The treatment of occupational injuries and diseases is the direct concern of an employer, and the facilities and physicians provided by him for that purpose must remain within his discretion. The employer is best served in these instances by physicians and surgeons who observe the general rules of ethics of their profession. Especially the following points of conduct are considered important:

(a) It is not ethical for an industrial surgeon, while caring for an industrial injury or disease case, to urge the patient to have a concomitant and coincidental disease treated by himself at the worker's expense.

(b) Once a case of questionable liability to the employer is diagnosed as being of non-occupational origin, the patient is to be referred to his personal physician for further care.

(c) In general, a physician or surgeon is not to use his industrial affiliation as direct means of gaining a private practice among plant workers. Emphasis is placed here on solicitation, low fee arrangements, and insinuation of reprisals against those workers who insist on care by physicians of their own choice.

Companion obligations rest with non-industrial physicians and surgeons in these matters:

(a) When a private physician suspects the diagnosis of an occupational disease or injury in a patient, he should, with his patient's permission, communicate the information to the proper plant doctor.

(b) When differences of opinion exist as to the compensability of medical and surgical conditions, the private physician, with the permission of his patient, is to confer with the plant doctor.

(c) Statements to workers that occupational diseases or injuries were not properly treated accomplish nothing constructive, and in any case

the expression of such opinions is to be withheld until there has been consultation with the plant physician for the purpose of ascertaining all pertinent facts.

3. Health Supervisory Programs.—Health Supervisory Programs may be properly carried on by an employer's medical personnel, if the purpose of the program be any or all of the following:

(a) To discover cases of occupational disease among employees exposed to known health hazards.

(b) To diagnose all possible illnesses which may influence adversely the earning capacity of workers or plant safety.

(c) To determine if workers returning from sickness absences have recovered sufficiently to carry on their jobs without injury to themselves or endangering the safety of others.

With respect to such programs the society considers certain ethical principles to be basic. They are:

(a) The results of clinical examinations must be made available to the personal physicians of the examined employees.

(b) No influence is to be brought to bear on employees in their selection of personal physicians for the correction of physical defects.

(c) No treatment for non-occupational diseases or injuries to be offered at the company's medical department, except in minor cases when enough treatment may be furnished a worker to make it possible for him to complete a turn of work with a minimum of injury and discomfort to himself.

(d) It is recognized that the plant physician is best qualified to judge a worker's ability to return to his particular job after an illness. In the interests of harmony in the medical community, however, when there is conflict of opinion in such cases between the worker's personal physician and the plant physician the latter shall, at the request of the personal physician, consult with him on the case.

4. We recommend that all industries have doctors of their own choice, who are to act in the capacity of consultants or as attendants at plant medical departments.

We believe that records of the physical status of all employees are valuable as protection to both employer and employee.

5. It is against the policy of the medical profession to have any free medical examinations in any industry for whatever purpose, without it having been first submitted to and passed by the Council of the local medical society.

We believe in and encourage research work that may bring knowledge to the medical profession and benefit to mankind, but severely condemn the abuse of research for commercial purposes.

6. Medical Testimony before the State Industrial Board.—Any member of the Lake County Medical Society who has submitted expert medical testimony at a hearing before the State Industrial

Board in a suit for compensation may petition the Council to review all of the medical testimony submitted at that hearing. The petition must be made after a final decision in the case has been reached. The Council will have discretionary power in the matter of deciding whether or not to review the case. Once the decision has been made to review, the Council will make a reasonable effort to arrange a convenient time and place for the review. All of the physicians who submitted testimony at the hearing in question will be apprized of that time and place, and must be permitted to attend the review. The society has the duty to censure any of its members for apparently flagrant deviations from the society's standards of competency and honesty, as revealed in such a review.

Referred to the Reference Committee on Hygiene and Public Health.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

Referred to the Reference Committee on Miscellaneous Business.

ANTI-TUBERCULOSIS COMMITTEE

Referred to the Reference Committee on Hygiene and Public Health.

CONSERVATION OF VISION

Referred to the Reference Committee on Hygiene and Public Health.

HARD OF HEARING

Referred to the Reference Committee on Hygiene and Public Health.

WAR PARTICIPATION

DR. C. R. BIRD, chairman: The published report you have in your hands, and what I would like to submit is a supplementary report. (This was submitted by Dr. Bird.)

You will note that the figures from the Procurement and Assignment Service in Washington are broken down into state and county groups, giving the population, the number of physicians, and the ratio to the number of people. We have tried to maintain our own equilibrium so that the United States Public Health Service would not come in and take over, which is important.

Referred to the Reference Committee on Miscellaneous Business.

PHYSICAL THERAPY

DR. N. H. PRENTISS, chairman: I have this supplementary report to submit.

"Dear Dr. Prentiss:—

"I have read the report of the Committee on Physical Therapy of the Indiana State Medical Association, as published in THE JOURNAL of the Indiana State Medical Association. I do not consider this report vituperative. I am glad to see a state committee stand up and fight for its rights.

"I must again apologize for not having answered your letters. You remember you wrote three letters which I could not answer because I was sick in the hospital.

"I am writing to the Iowa State Medical Associa-

tion and recommending that they create a committee on physical therapy, citing your work as an example.

"Keep up your good work.

Sincerely yours,

JOHN S. COULTER, M.D.,
Chairman, Council on Physical Medicine,
The American Medical Association."

Referred to the Reference Committee on Public Policy and Legislation.

MEDICAL RELIEF

Referred to the Reference Committee on Public Policy and Legislation.

RURAL MEDICAL CARE

DR. F. S. CROCKETT, chairman: A letter from Doctor Smith has been added to the published report, in which he reports on a trip with the members of the Farm Security Administration on Medical Care. After that I had a letter from Doctor Shideler, of Lafayette, in which he enclosed a survey of Crawford and Orange counties. The point they wished to call to our attention, as a medical profession, was the low economic state of the farmers in southern Indiana, of which Crawford and Orange counties are typical, and asking for help in this problem as related to medical care. They point out that the people are living on little money; that six hundred dollars would be the individual or family total income of a large portion of the population; that if they had any kind of catastrophe—a serious illness that required a nurse or hospital—they could not meet it; and that there were instances where homes had been lost because of such expense. Part of this problem is due to the small number of doctors in that part of the state, something like one doctor to three or four thousand population. This problem is being stressed by this farm group, and they would like to have it brought to our attention.

Referred to the Reference Committee on Public Policy and Legislation.

OPA MEDICAL ADVISORY COMMITTEE

DR. C. L. RUDESILL, chairman: *Mr. Chairman, Members of the House of Delegates, Gentlemen:* This is a supplementary statement of the OPA Advisory Committee.

Since the OPA Committee's report was published in THE JOURNAL of the Indiana State Medical Association, our committee had another meeting with Mr. Paul H. Moore, District Food Rationing Officer. Because certain meats were removed from ration lists, new and stringent directives were sent out from the national OPA to District food rationing officers. We learned that unrationed meats could not regularly be obtained at all markets, and that patients were unable to get sufficient rationed meat on their allotted points. In order to relieve this situation, we all agreed that there should be a more generous allowance of meat and fat points. This new ruling should correct any hardship that may

have resulted from the last two directives from the national OPA.

Referred to the Reference Committee on Hygiene and Public Health.

COMMITTEE ON LAY DOMINATION OF MEDICAL PRACTICE

DR. W. D. GATCH, chairman:

Mr. President and Members of the House of Delegates:

We respectfully submit the following statements and recommendations:

DANGER OF LAY DOMINATION

Your committee believes that lay control is the chief cause of the evils which afflict medical practice. Our opinion is that far more laymen than doctors now make a living out of medical care. They have a well-established vested interest in it. They seek to mechanize and commercialize medical practice. They are a danger to our professional unity. They govern many of our hospitals. They largely control medical education. They deluge the public with information and misinformation on medical subjects. They are taking the control of nursing from us. They are promoting schemes of hospital and sickness insurance which are a menace to the free practice of medicine. Social and welfare workers are interfering more and more with the actual medical care of patients. Laymen, with the help of some physicians, are promoting schemes to socialize medical care completely. In brief, our profession is in danger of passing entirely under lay domination.

The special privileges we as a profession enjoy have been granted us by society on the theory that our possession of them is for the general good. We are, therefore, of the opinion that our opposition to lay control (in other words, to the loss of our professional privileges) must be based on the argument that it is not for the good of society—not on the argument that it is harmful to physicians. We believe that the arguments in support of this contention are conclusive. The following are a few of them:

1. Laymen and physicians who have never had actual experience in medical practice do not know what good and necessary medical care is. They do not know the difference between quackery and honest medical service. Their ideal is to apply commercial techniques to medical care. The number of human ills would increase under any system they could devise.

2. Advocates of lay control of medical care assert that it would protect the people from unethical treatment. A doctor who is dishonest under the present system of practice will not become honest under another system. No one but a physician or a group of physicians is a competent judge of what is or is not unethical practice. Experience has demonstrated that lay control invites unethical practice by physicians.

3. Experience has shown also that lay control of medical care means a great deal of unnecessary, harmful, and expensive medical care; also,

that it means the support of a great army of lay parasites.

4. Lay control would rob the patient of his right of privileged communication—too many people would know his secrets.

5. Our observation of the results of mechanized medical care has shown us that it increases the number of psychoneurotic disorders.

RECOMMENDATIONS

Our committee has been unable to devise any simple or easy method for curbing lay control of medical practice. It believes that the first and most important thing to do is to convince every physician of its evils, its present extent, and of the importance at this time of professional unity in thought and action. The medical profession must see to it that its members observe its traditional system of ethics, and give the people good medical care. This will greatly strengthen its position, because it can stand before the court of public opinion with clean hands.

The committee debated at length what is good medical care. It concluded that the people need not so much, more medical care, as to be protected from unnecessary and inefficient medical care. We give a brief summary of its conclusions on this subject.

Medical care is of two kinds, normal and abnormal. Normal medical care is the care of people who are dwellers in communities having a well-established community life. Abnormal medical care is the care of people living under transient conditions, i.e., in the armed forces, in health resorts, in temporary jobs, et cetera. Normal medical care is satisfactory. Abnormal medical care is never entirely satisfactory. The committee believes that normal medical care is best given by competent general practitioners, assisted by a limited number of specialists, both having access to hospitals which, under the complete control of physicians, give hospital care at actual cost. Lay control would give abnormal medical care to all the population. We have already stated that the advocates of it do not know what good and adequate medical care is, and that the plans they propose would mechanize it, make it unduly expensive, and fasten on it a multitude of lay parasites. This committee believes that the best way to combat these schemes is to strengthen the position of the general practitioner. We believe that no valid argument can be made against the claim that the best, and certainly the cheapest, medical care is that given by a competent general practitioner. He has the affection and confidence of his patients. He knows their family history, personal traits, vices and virtues. Any plan of medical care which is not built around the general practitioner is abnormal and unsatisfactory. The purely functional complaints of patients, which make up perhaps 50 per cent of all their complaints, cannot be successfully handled by clinics of specialists. The general practitioner can treat them more successfully than anyone else.

The people of Indiana have a settled community life. The state has a very small number of tran-

sient residents. In normal times every patient of the state is within easy distance of a hospital and a physician. We do not have the problems existing in Detroit, New York, Florida, or Los Angeles. The committee, therefore, sees no reason why any radical change of the present form of medical practice in this state should be contemplated. It believes that the medical profession of this state should run its own affairs in a way which it deems to be in the best interest of the people of the state.

Almost every doctor under fifty years of age is now away from home in the armed forces. Medical practice is being done by men over fifty, who are overworked, discouraged, and in no mood to put up a vigorous fight. Our colleagues have made a splendid record in the armed services. When they come home they will be in a powerful position to preserve the established privileges of the medical profession. They will be influential members of a group which will control the affairs of this country for the next forty years.

This committee, in light of the foregoing considerations, makes the following recommendations:

1. That the House of Delegates at this time take no action which will in any way affect or change the present plan of medical practice, and do all it can to defend the traditional privileges of the medical profession.

2. That every effort be made to preserve and strengthen our county medical societies, and to inform all our members on the dangers which threaten medical practice; that the medical societies be urged to devote their best efforts to enforcing the code of medical ethics, and to encourage their members to give satisfactory medical care to the people. This will do much to overcome the danger of state regulation.

3. That the state medical society and the county medical societies start at once a vigorous fight to regain or hold control of hospitals, and to repeal the law which limits membership on the boards of county hospitals to laymen.

4. That the state medical society and the county medical societies do everything possible to promote the standing of the general practitioner; that to this end a section on "General Practice" be established in the state society; that to this end also plans be adopted for making general practitioners specialists with professional standing equal to that of the already-established specialists. By this we mean specifically that opportunities be provided for the training of general practitioners, and for their examination and certification to the public as specialists in General Practice. The committee can see no reason why this cannot be done. A competent general practitioner certainly needs to know more than any of the present recognized specialists.

5. That the state medical association, by every possible method, inform the public on the problem and true facts of medical care.

W. D. GATCH, M.D., Indianapolis, *Chairman*
 O. O. ALEXANDER, M.D., Terre Haute
 HERMAN BAKER, M.D., Evansville
 A. P. HAUSS, M.D., New Albany
 WALTER BAKER, M.D., South Bend
 H. O. MERTZ, M.D., Indianapolis
 WILL MOORE, M.D., Muncie
 C. S. BLACK, M.D., Warren
 F. T. ROMBERGER, M.D., Lafayette

Referred to the Reference Committee on Public Policy and Legislation.

SCIENTIFIC EXHIBIT

Referred to the Reference Committee on Sections and Section Work.

REPORT OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION

Referred to the Reference Committee on Reports of Officers.

COMMUNICATIONS

THE PRESIDENT: All communications have been disposed of, with the exception of a letter from Major Edwin L. Libbert, and since that has to do with physical therapy it will be referred, with the report of Doctor Prentiss' committee, to the Reference Committee on Public Policy and Legislation.

DR. J. E. FERRELL: I wish to announce that the delegates from the Sixth District have elected Dr. W. U. Kennedy, of New Castle, to take the place of Dr. Samuel Kennedy, of Shelbyville, as Councilor from the Sixth District.

NEW BUSINESS

DR. CHARLES N. COMBS, Terre Haute: I would like to offer this resolution:

WHEREAS, it will soon be one hundred years since the first session of the Indiana State Medical Association, which was held in Indianapolis on June 11, 1849; and

WHEREAS, this centennial should be celebrated with suitable ceremony, and should be the subject of considerable attention and thought,

THEREFORE BE IT RESOLVED that the incoming president appoint, in 1945, a special committee to make preliminary plans for this important event.

Referred to Reference Committee on Publicity.

RESOLUTION FOR THE APPOINTMENT OF A COMMITTEE ON MEDICAL EVIDENCE

DR. H. B. ANNIS, Bluffton: I wish to submit this resolution for your consideration:

WHEREAS, severe criticism has sometimes been made of the medical profession as a whole because of sharply-conflicting testimony given by physicians in regard to medical questions, and because in some instances of the apparent improbability of the truth of such evidence; and,

WHEREAS, courts and other agencies of government, having the obligation to find the true facts as the basis for the determination of legal questions, are sometimes unable to satisfy themselves as to what medical testimony to believe, and what not to believe; and,

WHEREAS, the Indiana State Medical Association wishes to protect its members and the medical profession against unjust criticism, and to be as useful as possible in establishing the truth where medical questions are involved; therefore,

BE IT RESOLVED that the president of this association is hereby authorized and directed to appoint from the members of this association a chairman and four others to serve as a committee to be known as the Committee on Medical Evidence, which committee shall be empowered and have the duty to review the medical evidence in those cases in which such evidence has been introduced and in which, for any reason, those having the responsibility for the decision of the cases may desire such review; and

BE IT FURTHER RESOLVED that said committee shall have no disciplinary power but shall have power only to review the medical evidence; to counsel with the medical witnesses and other members of the profession; and to submit their opinion of, and comments upon, the testimony given, to those having the duty to decide the cases involved, and to the Executive Committee of the state association for such further action by the Executive Committee as it may deem appropriate; and

BE IT FURTHER RESOLVED that this resolution be given such publicity as the Executive Committee may deem appropriate for the purpose of bringing it to the attention of courts and other agencies of government who, in the judgment of the Executive Committee, might be interested in knowing that the services of such committee are available.

Referred to the Reference Committee on Public Policy and Legislation.

DR. ERNEST RUPEL, Indianapolis: On your chairs you will find a copy of "The Health Platform for the Coming Years." Doctor Rice found it impossible to be here, and he asked me to say that he has given the matter considerable thought. He wishes to submit a plan for some changes that he hopes will be for the better, and he also hopes you will consider it and make whatever recommendations you wish.

Referred to the Special Reference Committee on State Board of Health Program.

No further business appearing, on motion of Dr. Charles N. Combs, duly seconded, the House of Delegates adjourned until seven-fifteen, Thursday morning, October 5, 1944.

The official Membership Roster will appear in the December issue of THE JOURNAL.

The names of those who have not paid their 1944 dues will not appear in this list.

HOUSE OF DELEGATES

(INDIANAPOLIS SESSION, 1944)

Second Meeting

The second meeting of the House of Delegates, a breakfast meeting, was held October fifth in the Riley Room of the Claypool Hotel, Indianapolis, convening at seven-fifteen; the president, Dr. J. T. Oliphant, presiding.

Roll-call of delegates showed the following members present:

County	Delegates
Allen	M. B. Catlett, Fort Wayne M. R. Lohman, Fort Wayne William C. Wright, Fort Wayne
Bartholomew	J. E. Dudding, Hope
Benton	V. L. Turley, Fowler
Boone	Ralph J. Harvey, Zionsville
Carroll	Max R. Adams, Flora
Cass	B. W. Egan, Logansport
Clark	E. P. Buckley, Jeffersonville
Clay	J. F. Maurer, Brazil
Dearborn-Ohio	G. S. Fessler, Rising Sun
DeKalb	John Showalter, Waterloo
Delaware-Blackford	Clay A. Ball, Muncie
Dubois	Paul J. Blessinger, Jasper
Elkhart	A. C. Yoder, Goshen
Fayette-Franklin	E. M. Glaser, Brookville
Floyd	C. E. Briscoe, New Albany
Fulton	A. E. Stinson, Rochester
Gibson	C. M. Clark, Oakland City
Hamilton	C. M. Donahue, Carmel
Hancock	Joseph L. Allen, Greenfield
Hendricks	O. T. Scamahorn, Pittsboro
Harrison	William E. Amy, Corydon
Howard	Elton R. Clarke, Kokomo
Huntington	G. M. Nie, Huntington
Jackson	L. H. Osterman, Seymour
Jay	George V. Cring, Portland
Johnson	Oran A. Province, Franklin
Lake	H. W. Eggers, Hammond C. R. Pettibone, Crown Point P. Q. Row, Hammond Robert M. Kelsey, LaPorte Claude Dollens, Oolitic
LaPorte	A. W. Elsten, Anderson
Lawrence	Otto H. Bakemeier, Indianapolis
Madison	John E. Dalton, Indianapolis
Marion	George J. Garceau, Indianapolis E. Vernon Hahn, Indianapolis Goethe Link, Indianapolis Marlow W. Manion, Indianapolis Ben B. Moore, Indianapolis W. P. Morton, Indianapolis R. H. Moser, Indianapolis Roy V. Myers, Indianapolis Harold C. Ochsner, Indianapolis J. O. Ritchey, Indianapolis Ernest Rupel, Indianapolis William N. Wishard, Jr., Indianapolis
Marshall	A. A. Thompson, Tyner
Miami	F. M. Lynn, Peru
Montgomery	T. Z. Ball, Crawfordsville
Noble	A. L. Fipp, Rome City
Orange	C. E. Boyd, West Baden Springs
Owen	R. H. Richards, Patricksburg
Parke-Vermillion	S. C. Darroch, Cayuga
Posey	J. R. Ranes, Mt. Vernon
Putnam	V. Earle Wiseman, Greencastle
Ripley	R. Lee Smith, Osgood
Rush	C. C. Atkins, Rushville
St. Joseph	Morris Balla, South Bend D. W. Frash, South Bend A. S. Giordano, South Bend

County	Delegates
Shelby	W. D. Inlow, Shelbyville
Sullivan	J. R. Crowder, Sullivan
Switzerland	L. H. Bear, Vevay
Tippecanoe	Gordon A. Thomas, Lafayette Earl Van Reed, Lafayette Robert R. Acre, Evansville Minor Miller, Evansville C. W. Cullnane, Evansville Ernest O. Nay, Terre Haute M. C. Topping, Terre Haute O. G. Brubaker, North Manchester
Vanderburgh	Claude B. Paynter, Salem
Vigo	Harry P. Ross, Richmond W. A. Thompson, Liberty Paul A. Garber, South Whitley
Wabash	
Washington	
Wayne-Union	
Whitley	

Councilors

First District	I. C. Barclay, Evansville
Second District	H. C. Wadsworth, Washington
Third District	A. P. Hauss, New Albany
Fourth District	J. C. Elliott, Guilford
Fifth District	A. M. Mitchell, Terre Haute
Sixth District	W. U. Kennedy, New Castle
Seventh District	W. L. Portteus, Franklin
Eighth District	E. H. Clauser, Muncie
Ninth District	F. T. Romberger, Lafayette
Tenth District	W. H. Howard, Hammond
Eleventh District	C. S. Black, Warren
Twelfth District	A. Jerome Sparks, Fort Wayne
Thirteenth District	Alfred Ellison, South Bend

Past Presidents

W. R. Davidson, Evansville
E. M. Shanklin, Hammond
Charles N. Combs, Terre Haute
George R. Daniels, Marion
F. S. Crockett, Lafayette
J. H. Weinstein, Terre Haute
R. L. Sensenich, South Bend
Karl R. Ruddell, Indianapolis
M. A. Austin, Anderson

Officers

President, J. T. Oliphant, Farmersburg
President-elect, N. K. Forster, Hammond
Treasurer, A. F. Weyerbacher, Indianapolis

Delegates to A.M.A.

Don F. Cameron, Fort Wayne
Homer G. Hamer, Indianapolis

ELECTION OF OFFICERS

Election of officers resulted as follows:

President-Elect: Jesse E. Ferrell, Fortville

Treasurer: A. F. Weyerbacher, Indianapolis

Delegates to A.M.A.: H. G. Hamer, Indianapolis;
George R. Dillinger, French Lick.

Alternates: Karl R. Ruddell, Indianapolis; A. S. Giordano, South Bend

PLACE OF MEETING

Place of Meeting for 1945: *French Lick*

THE PRESIDENT: I take great pleasure in introducing Dr. Frank H. Lahey.

DR. FRANK H. LAHEY, Boston: I do not want to make a speech, but I do want to tell you how sorry I am not to have been here last night, but I am very glad to be here this morning. Every plane between

here and Albuquerque is grounded. I had an appointment with an eastern society for today, but that runs over until tomorrow, so I can be there. I am delighted to be here this morning and apologize in person for not being here last night.

Election of Councilors:

First District—I. C. Barclay, Evansville

Fourth District—Charles F. Overpeck, Greensburg

Sixth District—W. U. Kennedy, New Castle (to succeed Samuel Kennedy, Shelbyville)

Seventh District, Charles A. Weller, Indianapolis (pro tem)

Tenth District—W. H. Howard, Hammond

Thirteenth District—Alfred Ellison, South Bend

REPORTS OF REFERENCE COMMITTEES

SECTIONS AND SECTION WORK

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The Reference Committee on Sections and Section Work wishes to report as follows:

We recommend that the Committee on Scientific Work be commended for a program that is especially timely and excellent.

The several sections have arranged programs on various subjects by men of outstanding ability, and are to be congratulated for securing such men in these busy times. The members of the Indiana State Medical Association are fortunate to have programs of the high order that are provided, and we therefore resolve that the House of Delegates extend a vote of thanks to all who have participated in their several capacities.

MINOR MILLER, M.D., *Chairman*
O. G. BRUBAKER, M.D.
MORRIS BALLA, M.D.
V. L. TURLEY, M.D.
O. H. STEWART, M.D.

THE PRESIDENT: Doctor Lahey has consented to speak for a few minutes, and we will be glad to hear from him now.

FRANK H. LAHEY, M.D., Boston: I am sure you have had a long and interesting session, and I do not want to make a lengthy speech. I do, however, have a few things that I want to get before you and I believe I can do it in about five minutes.

To begin with, I would like you to know that it is the unanimous feeling of the Procurement and Assignment Service that it was set up as a wartime agency, and that at the declaration of peace it assumes that its duties are over; and it assumes that the responsibilities and the rights for distribution of committees, reorganization and everything else falls then properly on the shoulders of a non-governmental agency, preferably the American

Medical Association, as your representative. I am very sure that the Procurement and Assignment Service is sensitive to any suspicion that it possesses any desire whatever to develop into a Washingtonian bureaucracy. I hope that I will not be misunderstood when I say that I believe it is but natural for any group of men to fear lest their representatives who have become officers of the government in character take on the qualities and rights and privileges that the men who endorsed them and put them in their place never intended them to have. I assure you that while the Procurement and Assignment Service is proud of what medicine has done, and what it has done in aiding medicine to make the contribution it has, it will cease as soon as peace is declared and the members withdrawn to civilian medical personnel. So much for that. Such a recommendation has been unanimously passed by the board and submitted to Washington, and it is my hope that it will be submitted to the American Medical Association.

I'll just mention one or two things that might interest you: Demobilization, I think will interest you, and I am sure you will be glad to know that the Navy, of course, cannot undertake to demobilize, because it is a problem of how long the battles of the seas will go on, but it is not unreasonable to assume that the Army will be able to demobilize, at least partially, at some not too late date. I am sure you will be glad to know that G-1 under General Henry has already consulted with us and has expressed its desire to utilize Procurement and Assignment, and any information it has, in order to institute an orderly demobilization of the medical personnel. I cannot tell you what the demobilization will be in numbers because we have no information. There are to be nineteen centers throughout the country, and I believe the plan will be sound. If they demobilize one million men, we ought to get five thousand doctors back. As to priority, I think essential teachers should be demobilized first, because one important thing is to get the medical schools back on their pre-war plan. The first thing we want is the restoration of the quality of medicine. I think that the order of priority should be to restore the regular pre-war plan of teaching; and second, the early return of essential educators. Beyond that I have nothing to say. That, I think, is the real demand—to keep the quality of medicine in this country up to the highest standards.

Just one other thing, and that is a question often asked, "What will post-war medicine be?" As I have traveled through the various installations—mostly naval, and as I see the boys at the front, the first thing I notice is their very grave apprehension as to the future of medicine. What is medicine going to be like after the war? I do not know any more about that than you do. I do not believe that the changes about which they are so apprehensive will be as grave as you think they might be. I think there will be some modifications. I have had ideas about modification, and have talked about some of my ideas.

My first idea about changes was that we will get some plan of providing medical care. I do not think that we will get an ideal one because it will not give the general public, the lay public, what they want. I, personally—and this will shock you because it will be considered reactionary—I personally believe that the plan that would work out best for the people in the long run would be a cash indemnity plan, but that is too Utopian. You cannot make the people understand it. But I think a cash indemnity plan would do medicine less damage than any other plan. It would still leave free enterprise arrangement between doctor and patient. But the trouble is that the people—and this is said without any suggestion of criticism—the people of the planning type, the uplift type, the advanced-thinking type, so-called, are the type that want to force medical care on people, make them better by compulsion, and it cannot be done. The minute you try that you do the same thing that was done when we tried prohibition. It will not work that way. But that is the way I believe it will be done, because that is the popular idea. But if you do that, I think two things will be unfortunate. I do not care how high the ideals are—this is my personal view—I think probably the first time around the track, if compulsory, the first cycle under a state system or some so-called “medical insurance plan,” will be all right. I think the next will be not as good, and I think eventually it will be proved bad. Two states have a cash indemnity plan, Rhode Island and Connecticut. Connecticut found a private insurance company that was willing to underwrite it, and that should be ideal. Why? Because then you get sound, established business supervision. If you don't do that you might get governmental management, which means inferior management; and if you had medical society management the doctors are too busy and will not be able to do the job right. If you have a cash indemnity plan, it would be a compromise and would be good for medicine.

If we get the other plan, prepayment under medical society management—the plan I think we may get for medical care—there are some things that must be kept in mind. Again, this is my personal opinion. I think that you have to be very careful that the lack of good business management does not make companies undertake to make a policy attractive at your expense by including various things that you have to supply at a lower rate and under less desirable conditions, and that is the addition of various things such as x-ray laboratories, which will make the policy attractive, but it is offered at your expense.

In any insurance plan we should have three things: Free choice of doctor, and if you do not do that you will promote discord. Next, you should have an upper limit of income, but you do not get that because it is tricky—there are ways of slipping out from under. Set your income wherever you want it—say \$2,500, although I think \$3,000 is best.

But this is the thing I dislike. They write so-called “limited policies” which insure people who have an income over \$2,500, then give them a fee table for \$2,500, and then let them make arrangements when their income is above that with the doctor as to what they shall pay him. It will not work. As soon as you give a stereotyped policy there is a great disadvantage to the doctor in trying to arrange his fee. I believe very strongly that in the long run you will have difficulty in doing this. If you subscribe to this plan with the upper limit set at \$2,500 or \$3,000, you will subscribe to a type under which there should be no compromise. It should be \$2,500 or \$3,000, and everything beyond that should be arranged between the doctor and the patient. You must not lose the privilege of contact between doctor and patient. The third thing is sound supervision under state insurance commissioners.

Another thing is the so-called “diagnostic service.” We have heard a good deal about diagnostic services being set up in rural communities where medicine was at a low level. This at first seemed all right, but in my opinion it will not work over a long period. You cannot buy with money something which will keep up the quality of medicine. The quality of medicine is maintained at the source and not at the other end by purchase.

If, for example, Alabama, Mississippi, Louisiana, Georgia, or any other state in which it is complained that the standards of medicine are low, wishes to keep up its standards, it should have the responsibility and it should not be a national government responsibility.

We have, as everyone knows, high ideals about medicine and medical education and we have so raised the standards, and the number of medical schools has been cut down, that we do not produce enough doctors for many of our rural communities. What I suggest, for instance, is that states take the responsibility for medical schools, particularly such states as we have in New England where there are too few doctors, excellent examples of which are Maine and New Hampshire. Schools have been closed in both of these states, and if they could be opened, for instance the University of Maine at Portland and the Dartmouth two-year school made into a four-year school, we would produce doctors in the community where they are later to practice and they would stay there. This same thing is being considered in Connecticut. Connecticut has Yale, but they do not feel that it produces enough doctors for the state and they are now applying for a charter for a state school to be opened in Hartford. The same thing is taking effect in Alabama and in Utah where a two-year school is being made over into a four-year school.

This plan, I believe, is the logical approach toward the elevation of medical care, by fertilizing the plant at the root and not at the flower, and placing responsibility for the quality and quantity of medical care directly where it belongs—upon the state.

RULES AND ORDER OF BUSINESS

Nothing having been referred to this committee, it had no report to make.

MEDICAL EDUCATION AND HOSPITALS

House of Delegates,

Indiana State Medical Association.

Gentlemen:

Your Reference Committee on Medical Education and Hospitals approves the report of the regular Committee on Medical Education and Hospitals as submitted and published.

In addition, it urges the association to make an effort to have laws that prohibit physicians from being on the boards of hospital management repealed.

ERNEST RUPEL, M.D., *Chairman*

GORDON A. THOMAS, M.D.

GEORGE V. CRING, M.D.

HAROLD C. OCHSNER, M.D.

E. P. BUCKLEY, M.D.

PUBLIC POLICY AND LEGISLATION

House of Delegates,

Indiana State Medical Association.

Gentlemen:

(1) Report of Committee on Public Policy and Legislation. The reference committee recommends that the entire report, including the supplemental report, be accepted. The committee requests Mr. Stump to read the State Board of Medical Registration and Examination Bill that will be presented to the next legislature.

(2) The resolution for the appointment of a Committee on Medical Evidence. Your committee recommends the adoption of this resolution.

(3) Report of the Advisory Committee to the Bureau of Maternal and Child-Health of the Indiana State Board of Health. We heartily approve of the EMIC up to a certain point. Your committee approves the action of the American Academy of Pediatrics, in which the Academy condemns certain existing actions of the EMIC, enumerated as follows:

(a) That the Children's Bureau of the Department of Labor is actively engaged in the practice of medicine.

(b) That the whole EMIC be discontinued when the war is over.

(c) Your committee recommends the patient-physician relationship be preserved, and that the EMIC payments should be paid to the patient so that the patient should have the free selection of her physician.

(4) Report of Committee on Physical Therapy. Your committee commends the work of the committee in its efforts, realizing that the work that was done was very considerable in getting supplies. We recognize the minority report in its statement that the majority report was injudicious in the language used.

(5) Report of Committee for the Study of Lay Activity in Medical Practice. Your committee

recommends this report in full with special commendation for the ideas promulgated.

(6) Report of the Committee on Civic and Industrial Relations. This committee had no activities.

(7) Report of the Liaison Committee of the Division of Services for Crippled Children. This committee had no activities.

(8) Report of the Medical Relief Committee. We, your committee, heartily endorse this report. Also, we heartily endorse the supplemental report.

(9) Report of Committee on Rural Medical Care. Your committee endorses this report insofar as it is a report of an experiment in the field of medical care. We also endorse the addenda to this report.

(10) In regard to the correspondence from Dr. Libbert on physical therapy. We recommend that this be laid over for further study.

JESSE E. FERRELL, M.D., *Chairman.*

A. A. THOMPSON, M.D.

J. O. RITCHEY, M.D.

ALFRED ELLISON, M.D.

H. W. EGGERS, M.D.

ALBERT STUMP, Indianapolis: The bill that has been prepared for the committee is as follows: (See minutes of the first meeting of the House of Delegates for copy of bill.)

You will realize that the purport of the bill is to wipe out the present State Board of Medical Examination and Registration and create the Board of Medical Registration and Examination of Indiana. The State Board of Medical Examination was created in 1897. That was the Bill under which the first board was brought into existence and under which the schools were classified that would be recognized by the examining board. For some years there were five members, and the law provided that there had to be at least one member from each of the then recognized schools of medicine. In the beginning there was one physiomedic, one eclectic, one homeopath, and one allopath. That continued until 1901, when an osteopath was added, and in 1927, in order to get the injunction feature into our enforcement law, the Medical Practice Act was set up so that instead of having a trial in the criminal court an order could be issued by the judge without any jury. In order to get that law through it was necessary to make compromises, and pursuant to an arrangement made under that necessity there was added a representative of a school or system having the largest representation in the state, yet not represented, and that happened to be the chiropractors, so that now there is one chiropractor and one osteopath on the board, and five physicians who were appointed as I have mentioned. The last physiomedical school went out of existence in 1903, and I believe that the last man of that school in the state is now serving on the board. If that man dies the board could not continue. The last eclectic school went out of

existence in 1939, and the same situation exists there as in the case of the physiomedics—if that man on the board dies, the board could not operate under the existing law. Instead of maintaining the four distinctions under which the board has operated until now, this Bill provides for five medical men—five graduates of recognized medical colleges, such as Indiana University, Rush, and Northwestern.

I take the time to explain this because this will be one of the important bills to come before the legislature. Of course, it must have your approval, and also your support.

We have adopted the language which was used in the State of Indiana when several boards were wiped out in 1933, when a new governor came in. When we wipe out this board now we will immediately transfer the present functions to the new board. That is all that amounts to. I hope it will receive your support.

DR. JESSE E. FERRELL: Do you not think you should leave out the word "regular"? We will have a lot of opposition, from whatever medical schools that are left which are not allopathic.

DR. BEATTY: It could be "licensed" physician.

MR. STUMP: As amended it would read: "(a) Five (5) reputable physicians who are graduates of recognized medical colleges with the degree Doctor of Medicine and hold unlimited licenses to practice medicine in the State of Indiana."

A MEMBER: Do you plan to have a chiropractor on the board?

MR. STUMP: Yes, one chiropractor, one osteopath, and five physicians who hold unlimited licenses to practice medicine in the State of Indiana. The bill reads, "(c) One (1) reputable practitioner of that system or method of healing not represented under (a) and (b) above which has the largest numerical representation of practitioners or members in the state, who shall be a graduate of a recognized school or college teaching said system or method and licensed to practice it in the State of Indiana." We have taken out the word "recognized." There is no recognized school of chiropractic. If we do not take it out we furnish them with additional argument, for if we leave it in they have no voice at all.

DOCTOR BEATTY: This new bill is not discriminatory against the men who are eclectics or physiomedics. If there are any of those men here, do not feel that you are being discriminated against. You can still be appointed to this board.

DR. W. R. DAVIDSON: I have not seen a copy of this bill, but after hearing it read I would like to make a suggestion which I think is fair and proper, from my experience of twenty years on the board. The bill states that applicants shall be from accredited institutions. I believe that it would be well to incorporate a clause which gives

the board authority to define accredited institutions, and also to state specifically that the board shall have the authority to determine from all available sources the standing of an institution. The Supreme Court has held that the board can accept the reports of the American Medical Association or the College of Surgeons, but the lawyer who is handling the suit always makes that point in his argument. In one case a threat of this kind forced all the members of the board to go to Chicago to make a personal investigation.

MR. STUMP: Instead of attempting to revise the bill at this time, if the House approves this bill it would, of course, be the understanding that the Legislative Committee might add any amendment that would be necessary to accomplish the purposes of the bill without it being incorporated at this time. It would not complicate the problems of this bill and should clarify the effect of the bill.

MR. STUMP: The resolution offered by Doctor Annis, of Bluffton, has been submitted to the Reference Committee on Public Policy and Legislation, and they recommend the adoption of the resolution authorizing the appointment of a Committee on Medical Evidence.

DR. SENSENICH: Do I understand that this is setting up a reviewing body to pass upon the validity of evidence? In other words, the original witness and someone else as a judicial body to weigh or possibly question the evidence?

MR. STUMP: One of the purposes of the resolution, as I read it, was this: that there be some committee on medical evidence that the physicians know exists, to whom the court, if there were conflicting statements concerning medical facts, might send a transcript of the evidence for their comment.

DOCTOR SENSENICH: What would be the position of the committee on the question of conflicting evidence?

MR. STUMP: Your committee felt that if the court, or any other fact-finding body, understood the facts, then the court, or fact-finding body, would be in position where they might move that the court refer this evidence to some extra-judicial body for its advice and comment upon the evidence.

DR. SENSENICH: What action could a man take whose evidence was questioned by a committee which had no authority, but were doubtful of the validity of the evidence, and were charging him with the presentation of evidence that was questionable?

MR. STUMP: The resolution provides that the committee which will be appointed under this resolution should have the right and duty to confer with the witness, and also . . .

DR. GEORGE R. DANIELS: I move that the resolution be laid on the table. (Seconded.)

MR. STUMP: The reference committee has approved the resolution. I have tried to explain it at the request of Dr. Annis, the delegate who proposed it, because of his unavoidable absence from this meeting.

THE PRESIDENT: It has been moved that that part of the report of the Reference Committee on Public Policy and Legislation relating to medical evidence be laid on the table. All those in favor signify by saying "Aye"; contrary, "No." It is carried.

DR. FERRELL: I move the adoption of the report of the Reference Committee on Public Policy and Legislation as a whole. (Seconded by Dr. Daniels and carried.)

REPORT OF THE REFERENCE COMMITTEE ON PUBLICITY
House of Delegates,

Indiana State Medical Association.

Gentlemen:

Your committee feels that the Bureau of Publicity has not only handled an immense amount of work during the past year, but has done it exceedingly well, and we fully approve its official reports. This bureau is a very important one, and its members are to be commended for their fine effort.

Their suggestion, also that embodied in the resolution of Doctor Combs, that arrangements be made for a centennial celebration in 1949, meets with the approval of this committee. We suggest that the president appoint a general committee, which should include the members of the Bureau of Publicity, to make adequate arrangements for this celebration. This committee may appoint subcommittees in each district to obtain historical data.

We suggest that this celebration be a part of the state meeting of 1949, and that a special issue of THE JOURNAL be dedicated to this centennial.

ROLLIN MOSER, M.D., *Chairman*

JOHN H. BARROW, M.D.

F. R. N. CARTER, M.D.

PAUL A. GARBER, M.D.

JON KELLY, M.D.

(On motion of Dr. Moser, seconded by Dr. Daniels, this report was adopted.)

REPORT OF THE REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

House of Delegates,

Indiana State Medical Association.

Gentlemen:

1. Report of Committee on Study of High School Athletics, approved.

2. Report of Committee on Mental Health, approved.

3. Report of Committee on Control of Cancer. We feel that the plan for establishment of diagnostic clinics should be explained more fully to the House of Delegates; otherwise, the report is approved.

4. Report of Committee on Venereal Disease, approved, including supplementary report.

5. Report of Committee on Industrial Health as published, approved. It is our opinion that the established code of ethics covers all of the supplementary report, which is a worthy amplification and application of said code of ethics to a specific field of practice.

6. Report of Anti-Tuberculosis Committee, approved.

7. Report of Committee on Conservation of Vision, approved.

8. Report of Committee on Hard of Hearing, approved.

9. Report of OPA Medical Advisory Committee and the supplementary report of this committee, approved.

GOETHE LINK, M.D., *Chairman*

C. C. ATKINS, M.D.

W. D. INLOW, M.D.

W. H. LANE, M.D.

P. Q. ROW, M.D.

DR. LINK: I move the adoption of this report. (Motion seconded and carried.)

DR. E. S. JONES, Hammond: I have been asked to make a supplementary report. (See minutes of the first meeting of the House of Delegates for copy of this report.)

DR. SENSENICH: This is an entirely different action from that laid on the table. This, apparently, is the proper approach in the way of improving the character of evidence. You have a perfect right to do this, but I judge that it would not be given publicity. Is that correct?

DR. JONES: That is correct.

DR. SENSENICH: Whereas in the other proposal, courts, compensation boards, or anyone who questioned the evidence or statement of a witness would be referred to a group, and the group who passed on it would be liable to the man upon whom doubt was reflected. The plan now submitted is not only workable but desirable. For years we have been endeavoring to clear up the matter of medical testimony. We did for a long time have a committee that had conferences with the State Bar Association and other groups in an effort to improve the character of medical testimony, and this seems like a practical approach to that question.

THE PRESIDENT: Do you wish to read the report from the *Handbook*?

DR. LINK: No, the supplementary report is quite long and has not been read.

THE PRESIDENT: That is the code of ethics presented by Doctor Jones?

DR. LINK: That is right; we thought it was a matter for the county society to determine and that we should not take the time of the state association when the established code of ethics covers it.

THE PRESIDENT: I will rule that time will not permit having it read now.

AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

Nothing having been referred to this committee, it had no report to make.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

House of Delegates,

Indiana State Medical Association.

Gentlemen:

We, your committee, approve the excellent administration of our president, Doctor Oliphant.

After reviewing the address of the president-elect, we approve it in the main.

We approve the report of the Executive Secretary; the report of the Treasurer; the report of the Chairman of the Council; the report of the Executive Committee; the report of THE JOURNAL Publication Committee, and the report of the delegates to the American Medical Association.

We approve the thought of the five-dollar assessment per member for the emergency. . . . This we leave for your disposition.

We approve Doctor Combs' centennial celebration resolution.

C. S. BLACK, M.D., *Chairman*

CLAY A. BALL, M.D.

ERNEST O. NAY, M.D.

J. R. CROWDER, M.D.

GEORGE J. GARCEAU, M.D.

DR. BLACK: I move the adoption of this report. (Motion seconded.)

DR. DANIELS: Being a poor boy, I move that we be not assessed for the duration. (Seconded.)

(Discussion of several members has been deleted in these printed minutes and is carried in the official minutes in the headquarters' office.)

DR. DANIELS: I want to make one thing clear, and that is that we should wait until the treasury is in worse shape than it is now before we assess the membership of the association five bucks. You can do as you please, but I do not want to lose my point—that we should not be assessed five bucks.

DR. ROMBERGER: I wish to say this, that whatever the House of Delegates wishes the Council and Executive Committee to do, we will be happy to endeavor to carry out. In regard to the five-dollar assessment, due to the wise, far-sighted management of our business, this association has been able to accumulate some funds. We are not poor; we have money, and we can spend that money the way this House of Delegates wishes it to be spent. A year ago additional expense was incurred, part of it because of carrying the dues of the boys in service, which is just and right, and as a result we dipped into our reserve slightly—

not a great deal. Now the question is one on which the Council wants your advice. Shall we continue to dip into the reserve year after year, or shall we make a small assessment to replace (and a little more) what extra expense we have incurred during the last twelve months? Due to the wise management of our money we have been able to accumulate a surplus. We are not broke. The organized profession in the sovereign State of Indiana is not broke, and I agree with Doctor Daniels that if you wish us to carry on for two or three years dipping into our surplus, that is your business; we can do that. We do not need to do it now, but next year possibly. Some of these funds have been put there by doctors now in the service. We think the House of Delegates should decide—shall we keep running for two or three years by dipping into our surplus, or shall we make an assessment? It is very simple, in a sense. I do not think that the Indiana State Medical Association, or any doctors in Indiana, are going to go broke, nor do I think that there ever will be a time when, should the Council or the Executive Committee come before the House of Delegates with a request for a five-, ten-, or one-hundred-dollar assessment, you will not give it.

DR. CATLETT: I think in view of the fact that all these doctors are making as much money, or more than they ever did, and also the fact that this assessment can be taken off their income tax, that we should have it.

DR. DANIELS: But we will not be through with it. I am not a secretary, but I know what it means when you go home and tell the members they have been assessed five bucks. If we are really so bad off, we had better pay one hundred dollars. But I see no reason for an assessment at this time of five bucks.

DR. VAN REED: Are we going to spend our surplus, and when the boys come back put an assessment on them to make up the deficit?

(Vote on Doctor Daniels' motion, lost.)

DR. CATLETT: I move that each member be assessed five dollars per year for the duration and one year thereafter. (Motion seconded by Dr. Rupel, and carried.)

REPORT OF COMMITTEE ON CREDENTIALS

This committee had no further report to make.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

House of Delegates,

Indiana State Medical Association.

Gentlemen:

The Reference Committee on Miscellaneous Business recommends the commendation of the Committee on Arrangements for the splendid work that

it has done in making the ninety-fifth annual convention a success.

The report of the Committee on Secretaries' Conference was approved. This committee hopes that the Secretaries' Conference will be continued in its present, most successful form.

The report of the Committee on Necrology was considered, and this committee's efforts in compiling a state medical history are commended. We hope that the present work of this committee will be carried on in order that such history may be completed before the centennial year of Indiana Medicine in 1949.

The report of the Committee on Indiana Inter-Professional Health Council was approved. Your reference committee considers this council of much importance in furthering the common interests of this association and the allied professions, and hopes that it will continue its present efforts, as exemplified in its report.

The report of the War Participation Committee was studied carefully. We desire particularly to commend Doctor Bird upon the splendid and exhaustive analysis he has prepared covering the statistical survey of active physicians and the ratio of physicians to population. We also commend him for the work he has done in meeting the very problems which his committee's report has raised. Doctor Paynter, of Salem, Washington County, pointed out that the shortage of physicians in some counties is not as great as set out in this committee's report. While there may be a dearth of physicians in one county, the adjoining counties are less hard hit and supply medical care from their fringes to the more arid regions. It is suggested that Doctor Bird's report made due allowance for these conditions in that his summary was a report of the over-all or average condition prevalent in the state. We feel secure in the knowledge that these problems are already in competent hands and can see no advantage to accrue from disseminating this report to each state chairman or any of the ninety-two county chairmen, nor in further publicizing the report in any way.

M. C. TOPPING, M.D., *Chairman*
J. C. ELLIOTT, M.D.
N. A. JAMES, M.D.
PAUL J. BLESSINGER, M.D.
M. R. LOHMAN, M.D.

(On motion of Doctor Topping, duly seconded, this report was adopted.)

REPORT OF SPECIAL REFERENCE COMMITTEE ON STATE BOARD OF HEALTH PROGRAM

House of Delegates,

Indiana State Medical Association.

Gentlemen:

Your committee begs permission to make the following report: After more than four hours of careful consideration of the mimeographed copies of the health platform for the coming years, as submitted by representatives of the State Board of

Health, we wish to commend these members and all of those who have had a part in formulating this forward-looking program. We are impressed with the fact that assumption has been made that our economic structure and social structure will be little changed from that which we have known in the past many years. With this viewpoint in mind, we would move the adoption of the platform, which, with certain changes made by the committee, reads as follows:

1. *"The Health of the Nation is the Wealth of the Nation."* It is impossible to suppose that our state or nation can continue at high efficiency unless it is able to attain in the great majority of its citizens a high level of physical and mental health. Whatever can be done in the direction of attaining such a goal must be done. In the words of Disraeli, "The Health of the People is really the foundation upon which all their happiness and all their powers as a state depend."

Every good purpose of government is dependent upon a state of bursting, bounding health in its citizens. A sick or ailing people cannot solve the problems of the next few decades.

2. *Public health is to a very large extent purchasable.* If this is true, then we should cease trying to spend as little as possible for public health, but should seek rather to spend such amounts for public health as may be needed to get the best results, provided, of course, the money is carefully and efficiently expended.

The salaries paid our health officers, our public health nurses, our sanitary engineers, and sanitary inspectors are low as compared with the salaries of men doing the same work in other states. As a result, we have great difficulty in holding well-trained men and women, and succeed poorly in inducing young people of ability into the specialized health work so vital to our welfare. We, therefore, urge upon the state and local divisions of government much more liberal health budgets.

3. *The health laws of Indiana should be codified.* These laws began to be put on the books about seventy-five years ago. They have been added law on law until they now make a confusing tangle of overlapping and conflicting statutes scattered everywhere through the law books of the state. Many of these laws are now obsolete; many are badly written; some are vicious, and all need to be integrated with other laws. To this end, we propose that a commission be created by the next legislature (1945), which group will be given the task of preparing a health code to be presented to the Legislature of 1947 for adoption.

We recommend the appointment of a liaison committee from the Indiana State Medical Association to be appointed by the president to offer its services to this commission.

Likewise, all of the hundreds of rules and regulations of the State Board of Health should be collected, studied, and rejected or approved, as the

case might be. Then they should be adopted again by the State Board of Health and finally promulgated in such a way as to be readily available to the people of the state. These two codes—one of the laws, and the other of the rules and regulations—are very badly needed. They must not be further delayed.

4. *Certain legislation is urgently needed now.* It should not wait until the code can be passed, possibly in 1947.

a. We need legislation clarifying the matter of birth and death certificates.

b. Indiana Health Officers, both part- and full-time, should be better paid.

c. Milk products should be made only from pasteurized milk, or as in the case of cheese must be allowed to age at least sixty days.

d. The law for the licensing of nursing homes for the aged needs to be clarified.

e. A strong but just law for the quarantine of recalcitrant persons suffering from chronic infectious disease is badly needed.

f. The requirement that premarital blood samples and laboratory reports on such samples be sent through the mail should be repealed.

g. A law licensing water purification, and sewage treatment operators, and requiring certain qualifications is needed.

5. *The Indiana State Board of Health should be reorganized.* We do not feel ready at this time to offer full details on this point, but feel that the executive functions and the discretionary functions of the Board should be separated. The executive functions would be under the State Health Commissioner, who is a direct appointee of the Chief Executive Officer of the State, the Governor, and would serve at his pleasure and subject to the approval of the Indiana State Board of Health. The State Health Commissioner should enforce the health laws of the state, prepare and carry out fiscal and budgetary responsibilities, be in charge of personnel, submit rules and regulations for the consideration of the Board and enforce these rules after they are passed. He should recommend policies to the Board, and should execute these policies once they are adopted. He should make recommendations for appointment of local health officers for the approval of the Board.

The Board, however, should be chosen in some other way than by direct appointment at the pleasure of the Governor. It should be bipartisan; the members should be appointed for a definite term of years, should be able to succeed themselves, should be staggered in their appointments, and should consist of at least one sanitary engineer, one layman, and three practitioners of medicine. The professional men on the Board should have the approval of the largest corresponding professional group in the state. The Board should exercise the legislative functions of their office, approve appointments (including that of State Health Commissioner) determine policies of public health practice,

and act as the advisor to the Commissioner in his work.

6. *There is a very great need as a part of the post-war planning that the health officers in charge of the various health administrative divisions of the state should be full-time health officers.* They should be physicians specially trained by experience or schooling for health work, and should devote full time to their duties. Nearly all other states are turning to the full-time health officer requirement. This is definitely an established public health practice. Such salaries as will attract high class professional personnel should be provided.

7. *As soon as practical, the state should be divided into health districts of such size that each district could have an efficient full-time health department.* County boundaries should be considered in this division when possible. A district might consist of a part of a county, a single county with its cities, or a group of counties of similar make-up, culture, and industry. Each such district should have a full-time health officer, a full-time public health nursing supervisor with an adequate staff of public health nurses, a sanitary engineer and/or public health sanitarians. If the county is large enough to support them, there should also be added health educators, demonstrators, and other such personnel.

The county commissioners should have the power to set up such districts. The expenses of such a district shall be paid locally when that is possible. When unable to pay all expenses of such an undertaking, the community itself should be able to ask for and get state funds to supplement its own funds, the amount of such outside help to be determined by careful study. The district should be under local control, but should, of course, cooperate insofar as possible with state agencies. If state funds are accepted, it will be necessary, of course, to submit to audit at that level.

8. *Each such district should have an adequate building for such a health department.* This building should be clean, attractive, convenient, and should serve as a general clearing house for all health matters. There should be a health library of books, pamphlets, posters, exhibits, films and the like for the teaching of the community in matters pertaining to health. The health center should be a source of justifiable community pride. The cost of such a building need not exceed one dollar per capita. A county of 30,000 could have such a building for approximately the cost of one mile of paved road, and it is recommended that this be provided by local funds.

9. *Indiana University School of Medicine should develop at once a strong Department of Public Health, and at the earliest practical moment a School of Public Health, at Indianapolis.* In such a school we could train physicians, dentists, nurses, sanitarians, and sanitary engineers (in conjunction with Purdue University) and teachers (in conjunction with the four state schools having departments

of education). Short courses for physicians, nurses, dentists, sanitarians, health officers, industrial hygienists, nutritionists, restaurant and hotel operators, tourist camp operators, managers of nursing homes, school janitors, bus drivers, teachers, housewives, and scores of other specialized groups, could be given. In this way, we here in Indiana could train in a very practical way the many health workers that we so urgently need to carry out the health work of the state.

There are only nine Schools of Public Health in the United States, and three others in the entire world. This is far too few to train the myriad of workers needed in an increasingly health-minded world. Already trained personnel is being attracted to foreign countries where many of them will remain for years, leaving us short of such trained help.

10. *The Indiana State Board of Health should have another building designed for the use of our laboratories and for the safe storage of our very valuable vital statistics records.* Such a building would cost, fully equipped, about \$350,000, and would fill the needs of the State Board of Health for years to come, unless health work expands very rapidly. This building should be erected as soon after the end of the war as is possible.

11. *An effort should be made to coordinate all the activities of the state which relate to public health.* For many years the State Board of Health and the State Department of Public Instruction have cooperated in a most effective way. This activity should be enlarged to include all the colleges of the state teaching health, to the end that their activities not overlap or run contrary to each other. The medical, dental, and nursing schools would be particularly interested in such integration, as should educational and engineering departments. Plans should be made whereby the State Board of Health could be more useful to the various college health services, the state institutions for the custodial care of the aged, the ill, the mentally deficient, and such other persons as would be under the Department of Welfare.

12. *Finally, there is great need for an Advisory Health Council to advise the State Board of Health; to make recommendations for local or state action; and to implement and sponsor effective action at local and state levels.* Such a council should serve without pay from any state or local governmental funds. The members should represent a wide range of public and private agencies.

This council could meet in Hurty Hall, of the Indiana State Board of Health building, or other convenient places at intervals of six months, or on call. Each representative should have one vote, but the decision of the body would carry weight only as a recommendation to the State Board of Health, the Governor, the legislature, or other legal or extra-legal organization. It should mold public opinion, and should carry no executive, legislative,

or judicial function. Smaller similar councils should be set up in each health district for a similar purpose.

It should be pointed out that there was a feeling on the part of some members of the committee, and some of the interested members of the State Medical Association present at this hearing, that paragraphs 6, 7, and 8 should be made a program for the future, and that no recommendations as to their acceptance by the House of Delegates at this meeting should be made. There was no feeling that the measure suggested in these paragraphs should be permanently abandoned, but it was their idea that this is no time to recommend any change from the present status. After due consideration it was decided by the majority members of the committee that the recommendations, as made above, should prevail.

The committee wishes to thank all of those individuals who have in any way contributed to the formation of this report.

HARRY P. ROSS, M.D., *Chairman*
E. R. CLARKE, M.D.
C. M. DONAHUE, M.D.
NAOMI DALTON, M.D.
W. A. THOMPSON, M.D.

DR. ROSS: I move the adoption of the report.
(Seconded by Dr. Egan.)

DR. BEATTY: I should like to call attention to the trend of the times. Some years ago when the association started an active movement against what we choose to call state medicine, one of the things mentioned, for instance, was that there might be some single law passed by Congress that would suddenly change the whole picture. And what have we seen in the last few years? We have seen acts passed by Congress providing for federal aid to states. The most pertinent thing in this report to which we have listened is the fact that they insist upon the use of local money. Whenever you use federal money you may be sure somebody down at Washington will say not only who shall spend the money, but how it shall be spent. The insistence upon the use of local money and keeping the control of public health and the practice of medicine in local hands, where you as citizens can see where and how far it goes, is the most important thing we have to do today. I would be very happy to see a reprint of this report carried to the legislators, showing that this House of Delegates opposes the use of federal funds in the health program of the State of Indiana. I want to call your attention to the fact that the State of Indiana has a surplus of forty million dollars, and there is little excuse for having money sent in from Washington, and under Washington supervision.

(Vote on Dr. Ross' motion, carried.)

THE PRESIDENT: The suggestion has been made that the assessment of five dollars, just approved, will not apply to honorary members.

REPORT OF SPECIAL REFERENCE COMMITTEE ON REPORT
OF COMMITTEE ON HEALTH INSURANCE

House of Delegates,

Indiana State Medical Association.

F. S. CROCKETT, M.D., *Chairman*
CLAUDE S. PAYNTER, M.D.
W. H. PORTTEUS, M.D.
J. H. WEINSTEIN, M.D.
T. Z. BALL, M.D.

Gentlemen:

Your reference committee has carefully read and discussed the report of the Permanent Study Committee on Health Insurance, as it appeared in the September issue of *THE JOURNAL*. We wish to commend the committee for the excellence of its report. It is evident that a large amount of time and study was devoted to its preparation. Your reference committee was in session all day yesterday, hearing those interested in this report.

The opinion expressed was overwhelmingly in favor of some plan being proposed by this session of the House of Delegates. It is recognized that the profession is not of one mind concerning the proposed medical service plan. Thinking along this line has fallen largely into three groups, the first group favoring the formation of a service plan by the physicians themselves, such as that published in the report of the permanent committee. The second group believes that an indemnity type health insurance should be formulated. In both instances the opinion of those appearing before the committee was that whichever type is agreed upon by this House of Delegates, the corporation formed to carry on the business should be organized, owned, and operated by members of this association, with the advice of the Council. There is a third group that believes that the association should enter into no plan whatever. While opinion differs as to the plan we should adopt, the majority favors an indemnity form of insurance.

The Permanent Study Committee on Health Insurance, after long study and canvass of similar activities in other states, proposed in their report that we organize our own non-profit corporation to provide medical service to certain wage groups. We recognize that such medical service groups have worked very well in other states, but we feel that the majority of those who appeared before our committee favored an indemnity form of insurance for Indiana. This method of direct payment of benefits to beneficiaries is in line with the accepted principles of physician-patient relationship that has always been the accepted policy of this association.

Your committee is of the opinion that the financing of the plan adopted should be carried out without the use of funds at present in the treasury of the state association.

Your committee, therefore, recommends and moves that the state association form and operate its own non-profit indemnity plan of health insurance.

Second, your committee recommends the appointment by the president, with the advice of Council, of a committee to carry out the provisions of the foregoing motion.

DR. CROCKETT: I am quite sure that no report which this committee could bring in would be satisfactory to all the members of this House of Delegates. Fundamentally, we are all opposed to anything in the way of socialization. However, you know that the trend of the times is toward greater socialization in agriculture, business, manufacturing, labor, and everything else, and medicine will not long be exempt. In fact, there has already been some infiltration, as mentioned by prior speakers. We do think that it is no longer a question of our likes and dislikes—the committee realizes that this thing is upon us, that we must do something ourselves or have something done for us, and the committee believes that the medical profession itself should be the agency which should do it.

The committee is very grateful to those who came before our all-day session yesterday and voiced their opinions. It was very helpful to us. We are especially grateful to Mr. Ketchum, of the Michigan Plan, who spent the entire day answering questions, and this was of interest and assistance in the formulation of our report. We have tried to voice in this report what we believe is the major feeling of you men and the other members of our profession.

DR. HAHN: Many of my colleagues share my opinion that the State Medical Association should beware of entering into the insurance business. To "form and operate" an agency to sell health insurance to the general public might expose us to difficulties which can hardly be anticipated. Even the direct sponsorship of an insurance company organized by others would expose us to criticism and attack from any and all disgruntled policy holders whose claims might not be allowed. As professionally trained men, I question whether we are adequately prepared even to select a suitable insurance "expert" to act for us. Would it not suffice to set up a special committee, prepared to engage and advise laymen, with reference to various types of insurance available to them? Could not such a committee lend its advice to the State Insurance Bureau, so that companies might be required to meet certain standards in the writing of their policies? Legislation might be needed to bring about this result, and I can see no objection to our going before the Legislature with a suitable request.

DR. SPARKS: Doctor Lahey suggested that doctors have nothing to do with organizing the company, but let an insurance company come in and do the work for them. They (the insurance company) will do the underwriting. At least that was my understanding of Doctor Lahey's suggestion. Was that the way it was understood here?

Apparently the committee has definitely decided that an outside insurance company should not do this for the association.

DR. CROCKETT: That is correct, and I will be glad to go into detail on that.

DR. SPARKS: But whether we have an indemnity plan or service plan, in either event the doctors would be the organizers of the group. I think it is important to keep this point in mind.

DR. SENSENICH: May I ask Doctor Crockett whether the committee recommends that the state association create its own company, or that a group from the state association investigate and work out some method of procedure?

DR. CROCKETT: The motion reads: "that the state association form and operate its own non-profit indemnity plan of health insurance." I move the adoption of this portion of the report. (Motion seconded.) I am not so sure that I am well enough informed to give you the picture as we had it yesterday. As you know, commercial companies must be run on sound business principles, and they are doing a good job for themselves. There are only nine companies in the United States that offer this type of insurance at present. They have to sell at a premium which is small enough to be salable, and they have to pay dividends and expenses out of these premiums. What is left after these are deducted is what the patient gets. All their efforts along this line are in the hands of laymen. But the effort in this medical plan is to keep within the control of the medical profession the entire operation—the professional side, the determination of fees—from the physicians' as well as the humanitarian standpoint. That was the consensus of opinion as we heard it yesterday, that in other states where the state medical association has formed similar groups they were able to bring about great economies in the operation of this sort of activity. Any commercial company must pay a commission for the sale of the policy, but their greatest source of expense is in the adjustment of individual liabilities. These things would be largely eliminated through a mutual, non-profit corporation, as suggested here, finding its origin in the state association. It was not the intent of the reference committee to say that the state association should own it. I think we really meant to say that the state association should sponsor it, as you see in the next resolution, "that the president should appoint a committee of members of this association who should operate and control this plan." It was disclosed yesterday that it might be possible to have an underwriting agreement with some insurance company wherein the profession could retain its determining position in relation to all the factors in which we are concerned, and yet have the insurance part of it left with highly-trained, specialized insurance men.

DR. SENSENICH: I think it would be unfortunate if the House were to consider the creation of its own company as the only possible procedure. I

think the action here should be to approve the establishment of some form of indemnity insurance, and if an underwriter could be obtained, as in Connecticut, that would carry that part of the business it might save us a lot of headaches.

(Here Dr. Sensenich spoke off the record.)

THE PRESIDENT: We have two things here—one is the adoption of some form of insurance by the association, and the other is that we adopt this specific kind of insurance. That means that we do it in a certain way. Could you not separate the motion in such a way that we could vote on one question at a time and get more intelligent vote?

DR. CROCKETT: The first resolution covered the point of adopting some non-profit plan. The second resolution recommends that the president appoint a committee to carry out the foregoing motion. I am sure I can speak for the committee that there would be no objection whatever to changing this motion so as to give this organizing committee discretionary powers covering the very thing that Doctor Sensenich has mentioned. I am sure if such a connection could be made, which the committee doubted, it might be satisfactory to us, but we would recommend that we control the dominating factor of professional relationship. There would be no objection to that. It is a matter of trial and error. We did feel very strongly that we were on sure ground when we recommended that it be our own organization—organized, and operated by our committee.

THE PRESIDENT: What I am trying to get at is that there are two questions involved: first, Shall we adopt some form of insurance? I should like to have an expression from the delegates as to whether or not we should do something about that. And then, what we should do and the manner in which we do it constitutes another question.

DR. CROCKETT: We are just trying to place on record the fact that we recommend a non-profit indemnity plan of health insurance. We stated "indemnity" specifically because we thought that was what you wanted. Our motion was to recommend and move that the state association form and operate its own non-profit indemnity plan of health insurance.

DR. NIE: I think the question to decide is whether we are going into the insurance business. That is a big job. Doctor Lahey suggested that some plans will not work. Then why adopt them? The very fact that indemnity insurance is handled only by a few companies, and life insurance by some eighty, shows that it is an undesirable business to be in. There are no accurate actuarial figures to follow on indemnity insurance such as are in use by Old Line Life Insurance Companies. You cannot run a non-profit organization of any kind. You have to pay bills, and if you only write indemnity insurance you still have to comply with the rulings of the insurance commissioner, and who is going to furnish the securities to qualify with the insurance department. I feel that we ought to

be careful about going into the insurance business. It is hot stuff. If you go into this as a state association, you will have to learn the business, and you will not get the good cases—you will get the bad ones. You will get some from Lake County, and will get some in Indianapolis, but not many north of Fall Creek. You will get the poor cases, and the insurance companies will laugh at you. Better stay off of it.

DR. WEINSTEIN: A great many questions came before this committee, and some of them you do not realize. I think Doctor Lahey said that while the medical profession opposed federal domination, we have offered no other plan; we have done nothing; we have stood aside and said, "Let somebody else do the planning." The fact is that the medical profession has been severely criticized because it has offered practically nothing. We have come to the point now where we have to offer some plan or the government will make a plan for us. We can take the Blue Cross, which offers medical service in connection with hospital service; it is not an indemnity proposition, it is a service proposition. But we absolutely refuse a service proposition. The majority of the committee were for an indemnity plan, but realized the impossibility, almost, of getting any commercial company to take this over. I feel that we are forced into a corner, and unless we do something the Federal Government will do it for us.

DR. BEATTY: It is a fallacy to believe that if we set up some sort of a voluntary system that this will act as a substitute for a Federal Government health insurance system. As a matter of fact, voluntary plans invite government systems. As an illustration of this, following the set-up of the New York insurance plan, the senator from that state, Robert Wagner, introduced his bill, providing for a federal health insurance system.

DR. CROCKETT: I think we should hear from Mr. Ketchum, of Michigan, where a service plan has been in use for several years. He has had a great deal of interesting experience as to what the costs should be, what it would mean in the way of management, and what the Michigan Association has done to solve this problem. Mr. Ketchum is an insurance man, formerly connected with the Insurance Department of Michigan. For some time he has been executive manager of the Michigan Plan, and he will be able to answer any questions in your mind as to whether a plan can be made to work. His experience, of course, has been with a service plan, but it is a comparable problem.

MR. JAY KETCHUM: You gentlemen have the same problem that every state association in the United States is facing. Fourteen state associations have organized non-profit plans. At the present time, with one possible exception, there has not been a financial failure in the bunch. There was almost a tragic failure in Michigan. A year ago last October they had . . .

(Miss Dillan's transcription ends here. From her notes is gathered the following information.)

Following further discussion by Doctors Senenich, Crockett, Romberger, Lahey, Nie, Olsen (of Iowa), Howard, Ross, and Mr. Ketchum, Dr. Howard made the motion that this entire matter be laid on the table and that a special meeting of the House of Delegates be called within sixty days to consider this question and make a final decision. (Motion duly seconded and carried.)

DR. WEINSTEIN: Speaking as a member of the special reference committee, I speak for myself and, I know, for the committee as a whole—our report produced exactly the results we anticipated. We intended to throw this question directly into the lap of the House for a free, open discussion on this controversial question. Our recommendation was a cross cut of all the information and testimony heard by us. We accomplished the purpose intended, and we feel well satisfied with the results.

Dr. Hauss presented a resolution in appreciation for the splendid entertainment provided by the Indianapolis (Marion County) Medical Society and the Woman's Auxiliary during the session, and thanking the officers and personnel of the Army Air Force Medical Services for the cooperation and help given by them in making the meeting a success; also the Indianapolis *Star*, *News* and *Times* and the press services—A.P., U.P., I.N.S., and the radio stations WIRE, WFBM, WISH, and WIBC, and the stations at Gary, Fort Wayne, South Bend, Terre Haute, Muncie, Richmond, and Kokomo.

Following the closing words of the president, and on motion of Doctor Daniels, the House of Delegates adjourned.

INDIANA STATE MEDICAL ASSOCIATION

GENERAL MEETING

The General Meeting was held in the Murat Theater, Indianapolis, on Wednesday, October 4, 1944, being called to order at 9:00 A.M. by J. T. Oliphant, M.D., Farmersburg, president of the Indiana State Medical Association.

Harry L. Foreman, M.D., of Indianapolis, president of the Indianapolis (Marion County) Medical Society, was presented by Bert E. Ellis, M.D., chairman of the Committee on Convention Arrangements, and offered greetings to members and guests in the name of that society.

The President's Address was read by J. T. Oliphant, M.D., of Farmersburg.

The following scientific program was presented: "Medical Aspects of Pressurized Aircraft," by Major General David N. W. Grant, Air Surgeon, United States Army, Washington, D.C.

"Functional Disturbances vs. Organic Heart Disease," Newell Clark Gilbert, M.D., Professor of

Medicine, Northwestern University Medical School, Chicago, Illinois.

"Indications and Methods of Use of Penicillin," Chester Scott Keefer, M.D., Wade Professor of Medicine, Boston University School of Medicine, Boston, Massachusetts.

"Indications for Radical vs. Conservative Treatment for Gynecological Conditions," Virgil S. Counsellor, M.D., Associate Professor of Surgery, University of Minnesota Graduate School, Minneapolis-Rochester, Minnesota.

"New Horizons in Management of Convalescents," Colonel Howard A. Rusk, M.C., Chief, Convalescent Training Division, Office of the Air Surgeon, Washington, D.C.

The meeting adjourned at 12:05 P.M.

SECTION ON MEDICINE

The Section on Medicine convened at 2:10 P.M., on Wednesday, October 4, 1944, in the Murat Theater, Indianapolis, the meeting being called to order by the chairman of the Section, Eugene F. Boggs, M.D., of Indianapolis.

Newell Clark Gilbert, M.D., of Chicago, Illinois, read a paper entitled "The Treatment of Rheumatic Fever." This was discussed by Robert M. Moore, M.D., of Indianapolis.

A. J. Sparks, M.D., of Fort Wayne, presented the subject "Upper Urinary Tract Symptoms of General Interest." Discussion by Walter P. Morton, M.D., of Indianapolis.

Chester Scott Keefer, M.D., of Boston, Massachusetts, presented the subject, "The Treatment of Blood Stream Infections and Meningitis with Penicillin."

Election of Officers resulted as follows:

Chairman, William M. Dugan, M.D., Indianapolis.

Vice-Chairman, Wemple Dodds, M.D., Crawfordsville.

Secretary, Marion R. Shafer, M.D., Indianapolis.

At the close of this session Dr. Newell Clark Gilbert presented a film showing the La Rabida Convalescent Home, Chicago.

The Section adjourned at 4:15 P.M.

SECTION ON SURGERY

The Section on Surgery was held in the Candidates Room, Murat Temple, October 4, 1944, with William H. Howard, M.D., chairman, presiding.

Major Randolph L. Clark, M.C., of the Aero Medical Laboratory, Wright Field, Dayton, Ohio, presented a paper on "The Evolution of the Treat-

ment of Pilonidal Cysts in Sinuses." A discussion followed by Dr. David A. Eisenberg, of Hammond.

E. B. Mumford, M.D., of Indianapolis, gave an extemporaneous talk, which was illustrated with slides, on "The Internal Fixation of Fractures." A discussion took place afterwards, in which the following took part: Frank W. Teague, M.D., of Indianapolis; John F. Lyons, M.D., of Cincinnati; Captain A. M. Bookstein, of Detroit, and George A. Collett, M.D., of Crawfordsville.

Leo K. Cooper, M.D., of Gary, gave a paper on "Surgery of Trauma and Its Importance as an Emergency."

Virgil S. Counsellor, M.D., of Rochester, Minnesota, discussed "Vesicovaginal Fistula." Following this presentation E. S. Jones, M.D., of Hammond; A. E. Newman, M.D., of Evansville; Lieutenant H. I. Kantor, of El Paso, Texas, and J. William Hoffmann, of Indianapolis, took part in a discussion.

The following officers were elected:

Chairman: George A. Collett, M.D., Crawfordsville.

Vice-chairman: J. Robert Doty, M.D., Gary.

Secretary: William N. Wishard, M.D., Indianapolis.

The meeting adjourned at 4:45 P.M.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

The Section on Ophthalmology and Otolaryngology met in the Murat Egyptian Room Foyer No. 1, at 2:10 P.M., October 4, 1944, the chairman, C. P. Clark, M.D., of Indianapolis, presiding. The following scientific program was presented:

Major Dillon D. Geiger, of Keesler Field, Mississippi, presented a paper on "Penicillin in Otolaryngology." Major John G. Bellows, M.C., read a paper on "Penicillin in Ophthalmology." Discussants of these papers were Colonel Gilbert C. Struble, of Billings General Hospital, and Gerald F. Kempf, M.D., of Indianapolis. In a general discussion that followed, Drs. O. G. Brubaker, of North Manchester; Herman S. Hepner, of Bloomington; Kenneth L. Craft, of Indianapolis; Edgar C. Davis, of Muncie; E. C. McBride, of Terre Haute; and Mortimer Mann, of Indianapolis, participated.

The following officers were elected:

Chairman: J. V. Cassady, M.D., South Bend.

Vice-chairman: Edgar Davis, M.D., Muncie.

Secretary: H. C. Wurster, M.D., Mishawaka.

SECTION ON ANESTHESIA

The Section on Anesthesia was called to order at 2:15 P.M., on Wednesday, October 4, 1944, in the Egyptian Room, Murat Theater, Indianapolis;

the chairman, Russell W. Kretch, M.D., of Hammond, presiding.

Ralph M. Waters, M.D., of Madison, Wisconsin, opened the scientific program with a paper on "Artificial Respiration," which was discussed by Floyd T. Romberger, M.D., of Lafayette, and George Rosenheimer, M.D., of South Bend.

Major Donald S. Thatcher, M.C., of Billings General Hospital, presented "The Correction of Protein Deficiency by Amino Acid Therapy in the Management of Surgical Patients." This paper was discussed by Philip L. Kurtz, M.D., of Indianapolis, and Captain Luther Gilliom, of Fort Benjamin Harrison.

Charles N. Combs, M.D., of Terre Haute, read a paper on "The First Nitrous-Oxide Anesthesia Administered by Dr. Horace Wells, December 11, 1844—A Memorial."

The following officers were re-elected:

Chairman: Russell W. Kretch, M.D., Hammond.
Vice-Chairman: Harry Knott, M.D., Plymouth.
Secretary: John M. Whitehead, M.D., Indianapolis.

The meeting adjourned at 4:25 P.M.

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

September 10, 1944.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; F. T. Romberger, M.D.; E. M. Shanklin, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Present at luncheon meetings were state and county legislative committeemen and councilors, members of the state legislative committee, and Dr. Joseph S. Lawrence, consultant to the Council on Medical Service and Public Relations, American Medical Association, Washington, D.C.

The statements of receipts and expenditures for July and August for the association committees and THE JOURNAL were approved.

Membership Report

Number of members September 9, 1944.....	3,342*
Number of members September 9, 1943.....	3,243
Gain over last year.....	99
Number of members December 31, 1943.....	3,344

* Includes 936 military members and 126 honorary members.

Treasurer's Office

Recommendation concerning an increase in dues or a special assessment to be placed before the Council and the House of Delegates at the annual session.

Expansion of Office

The committee was informed that Mrs. Audlane Waterbury has been employed in the Procurement and Assignment Service office, which eventually will enable Miss Reid, who has been doing the

Procurement and Assignment work, to devote her full time to state medical association duties.

The committee was also informed of the refusal of the Hume-Mansur Company to allow the state association to sublet space to the Office for Emergency Management for the use of the Procurement and Assignment Service.

1944 Annual Session, Indianapolis, October 3, 4 and 5, 1944

Those wearing state medical association badges will have the right to use the Athenaeum, across the street from the Murat Temple.

Annual dinner:

a. Informal.

b. To be held in Banquet Hall, Murat Temple.

Program to be held in Murat Theater.

c. *Speakers*: Frank H. Lahey, M.D., Boston;
Michael MacDougall, New York.

d. Special table to be arranged for national and state auxiliary officers, at the request of Mrs. James W. Baxter, Jr., state president.

e. Special table for ex-presidents and their wives and the councilors and their wives will be arranged under the direction of Dr. Charles N. Combs.

f. Inspection trip to Stout Field, scheduled for 2:00 P.M., Thursday, October 5. Members of the House of Delegates and their wives and auxiliary officers invited.

Special reference committee to handle report of the Permanent Study Committee on Health Insurance to be appointed by Dr. Oliphant. Anyone who has anything to say in regard to prepayment medical plans will be free to appear before this committee. Invitations to be sent to Jay Ketchum, manager, and Dr. R. L. Novy, president of Michigan Medical Service, and to Dr. Creighton Barker, of Connecticut, where they have a medical and surgical cash indemnity plan, to discuss these matters before the committee and the House of Delegates.

Funds for Woman's Auxiliary entertainment. The committee again disapproved allotment of any funds for Woman's Auxiliary entertainment.

Letter from the Office of Defense Transportation read to the committee. The committee felt that it was proper to hold the Indiana State Medical Association session this year as the session is so closely connected with the war effort.

Legislative, Legal and Social Security Matters

National

The committee discussed the Miller Bill, H.R. 5128, in regard to the deferment of medical students.

GI Bill of Rights. Are the provisions of this bill applicable to physicians in service? Albert Stump is to write a statement concerning this to be printed in THE JOURNAL.

Local

The legislative conference convened at 11:00 A.M., and the Executive Committee met with the legislative group for luncheon.

A draft of a bill to bring the present statutes concerning the State Board of Medical Registration and Examination up to date was presented to the committee by Albert Stump.

The State Board of Health postwar program, which involves legislation, is to be brought to the attention of the House of Delegates.

Future Medical Meetings

Invitations were received to attend the following medical meetings, and arrangements were made for the following officers of the state association to attend these meetings:

Wisconsin State Medical Society, September 18, 19, and 20—Forster and Hendricks.

Kentucky State Medical Association, September 18, 19, and 20—Nafe, McCaskey, Ruddell, and Hendricks.

Third District Medical Society, September 20, New Albany—Oliphant, Nafe, McCaskey, Ruddell, and Hendricks.

Michigan State Medical Society, September 27, 28, and 29—Forster, Howard, and Hendricks.

Prepayment Medical Plans, Group Hospitalization and Voluntary Health Insurance

Appreciation for the work done by Jay Ketchum, who has made several trips to Indiana to work with the Permanent Study Committee on Health Insurance, expressed by Executive Committee. The committee is to discuss the matter further at the next meeting.

Letter from Dr. A. C. Yoder concerning the scope of the proposal made by the Permanent Study Committee on Health Insurance brought to the attention of the Executive Committee. The scope of the work was discussed several times by members of the Executive Committee in conjunction with the members of the Permanent Study Committee on Health Insurance, with the result that it was felt the committee had the latitude of studying all types of prepayment plans and not merely limiting its study and recommendations to an indemnity plan.

The American Health number of the *Railroad Journal*, discussing prepayment medical plans and containing articles by Reverend Alphonse M. Schwitalla, S.J., dean of St. Louis University School of Medicine, and president of the Catholic Hospital Association; John Pratt, executive director, National Physicians Committee, and Don Hawkins, special agent for the American Health Insurance Corporation, brought to the attention of the committee.

Report on progress of Blue Cross made to the committee. The \$25,000 has been deposited in accordance with the law, but the company can not function until the \$25,000 in premium payments has been received. It is expected that this will be received within the next month and the organization will be ready to function under the laws governing mutual non-profit insurance organizations in Indiana.

Medical Economics

Question as to the right of an Army physician to do private practice brought to the attention of the committee. Following is a general provision from Army regulations concerning this subject:

"Private Practice by Medical Officers—If a citizen residing in the neighborhood of a military station or the residence of an Army medical officer desires the professional services of such officer, and the services of a private practitioner acceptable to him can not conveniently be obtained, it is regarded as not inconsistent with the regulations governing the Army for such officer to tender his services when this does not interfere with the proper performance of his official duties. Private or civil practice by Army medical officers in civilian communities, the needs of which are being satisfactorily met by civilian practitioners, will ordinarily be restricted to consultation practice with such civilian practitioners, and to emergency medical or surgical work necessary to save life or limb or prevent great suffering for which civilian practitioners are not immediately available. The establishment by a medical officer of an office for the purpose of engaging in civil practice is prohibited."

The committee discussed alleged unreasonable increases in hospital costs.

Complaint received from an Indianapolis physician that the Home Service Department of the Red Cross instructs those entitled to maternal and infant care under the EMIC program to go to the university hospitals. Questions were brought up as to who gives the Red Cross these instructions and what the state medical association is doing about it. Dr. Nafe was to investigate this and make a report at the next meeting of the Executive Committee.

War and Postwar Medicine

Report of Dr. C. R. Bird, chairman of Procurement and Assignment Service, concerning the ratio of physicians per 1,000 persons in Indiana brought to the attention of the committee.

Socialized Medicine

Clyde White, former head of the Social Service School of Indiana University, and now connected with Chicago University, is to discuss the subject of federal medical legislation (Wagner-Murray-Dingell Bill) at the State Conference on Social Work, November 16. Request that someone be placed on the program to answer White. The committee suggests that Albert Stump fill the place on the program for the state association.

Questionnaire from Indiana University School of Social Work in regard to the activities of the association brought to the attention of the association, and the committee approved answering this questionnaire.

Industrial Medicine

Industrial Medicine copied the article by Dr. Oliphant entitled, "Training of Industrial Physi-

cians," in its August, 1944, issue. The article was brought to the attention of the committee and received its hearty approval.

The Journal

The September, 1944, issue of *THE JOURNAL*, which is the Army Air Force and Convention Number, is the largest *JOURNAL* ever published by the state association (196 pages).

Request from out-of-state physician for professional card in *THE JOURNAL* approved by the committee.

Medical Defense

The group policy with the St. Paul Mercury Indemnity Company was discussed in the September *JOURNAL*. In addition, all members received letters from the Executive Committee concerning this group policy.

The St. Paul Mercury Indemnity Company will have a booth at the annual session, where all questions may be referred and answered for the physicians.

There being no further business, the meeting was adjourned.

LOCAL SOCIETY REPORTS

Carroll County Medical Society members met September fourteenth at the Welcome Inn, in Delphi, for dinner and a business meeting. The physicians had as their guests their wives, and Mrs. Esther Gregg, public health nurse. The county school immunization project was discussed.

Delaware-Blackford County Medical Society members held a meeting at the Roberts Hotel, on September nineteenth, for a discussion of current candidates and their relationship to medical legislation. The National Physicians Committee and other routine business was also discussed. Twenty-five members attended the meeting.

Elkhart County Medical Society members met at Hotel Elkhart, at Elkhart, on October twelfth. The speakers for this meeting were Colonel John Hall, and Lieutenant Colonel Richardson, of Gardiner General Hospital. They discussed "Neuropsychiatric Treatment of War Psychoses." In addition, a gift was presented by Dr. A. A. Norris, of Elkhart, to Dr. M. A. Farver, of Middlebury, who was honored upon the completion of fifty years of medical practice. Fifty-seven were present at this meeting.

Fort Wayne County Medical Society members held a meeting September fifth. The speaker of the evening was Dr. S. M. Rabson, pathologist at the St. Joseph Hospital, who discussed problems of medicine in the aged.

Grant County Medical Society members held a meeting at Marion, September fourteenth. Dr. M. S. Davis, of Marion, read an article published in the August issue of *THE JOURNAL*, entitled "Lay Domination of Medical Practice," which was followed by a discussion of the article.

The Hancock County Medical Society members met at the Cozy Hotel, east of Greenfield, on September thirteenth. There was a large attendance of members present to hear Dr. V. B. Scott, of Shelbyville, who spoke on "Some Aspects of Kidney Functions." A round-table discussion followed Doctor Scott's talk, during which health conditions and preventative medicine were discussed.

Montgomery County Medical Society members held a meeting at the Culver Hospital, at Crawfordsville, September twenty-first. The guest speaker was Guy W. Spring, of Indianapolis, who discussed the Blue Cross Plan. Nineteen members and guests were present at the meeting.

Floyd County Medical Society members met at New Albany on September eighth. The meeting was devoted to a general discussion of plans for the year. Nine members attended the meeting.

Howard County Medical Society members met at the St. Joseph Memorial Hospital, in Kokomo, on September first. The guest speaker was Dr. Donald Cook, of Lake Zurich, Illinois, who presented a paper on "Gastric Ulcer: Medical and Surgical Treatment." Seventeen members attended the meeting.

On October thirteenth, the members held another meeting at Kokomo. Lieutenant Commander George L. Kraft, of the Bunker Hill Naval Air Base, spoke on "Orthopedic Experience and Results in Puerto Rico." The talk was illustrated with motion pictures. Twenty members and guests attended the meeting.

The Indianapolis (Marion County) Medical Society members met on October tenth at the Indianapolis Athletic Club. This meeting was a business meeting, and employment of a full-time secretary was discussed.

At another meeting on October seventeenth numerous case reports were presented, including: "Strangulated Hernia in an Infant, Aged Two Weeks," by A. M. Denato, M.D.; "Chronic Urethritis Resistant to Chemotherapy," by Dr. R. J. Lewis, M.D.; "Megalomastia and Its Surgical Treatment," by J. C. Manning, M.D.; "Reduplication of Kidney Pelvis," by J. W. Hendricks, M.D., and "Generalized Carcinoma Simulating Miliary Tuberculosis," by E. C. Roll, M.D.

On October twenty-fourth a program by the medical section, First Troop Carrier Command,

Stout Field, was presented. Colonel R. J. Benford, Command Surgeon, was in charge of the program.

A meeting on October thirty-first was devoted to a symposium on "Poliomyelitis," with Dr. Gordon Batman as moderator. "Present Ideas of Etiology, Epidemiology, and Treatment of the Acute Stage," was presented by Lyman Meiks, M.D., and discussed by G. F. Kempf, M.D.; "Early Treatment of Paralysis," was presented by Carl D. Martz, M.D., and Frank W. Teague, M.D.; "Reconstruction Operations for Residual Paralysis," was presented by E. B. Mumford, M.D.; and "Occupational Therapy Program of the Marion County Society for the Crippled," was presented by W. S. Tucker, M.D.

Madison County Medical Society members met at the Mounds State Park pavilion for a dinner meeting on September eighteenth. The program included a motion picture demonstration of obstetrical spinal anesthesia by D. C. Hines, M.D., of Indianapolis, and also a demonstration of a new rapid method of skin suturing with a mechanical sewing machine. Fifty members and guests attended the meeting.

St. Joseph County Medical Society members met on September twelfth, at the Indiana Club, in South Bend. Many items of business were discussed by the forty-three members and guests present.

At another meeting held at the Indiana Club on September twentieth, sixty members and guests listened to a discussion of "Obesity," which was presented by W. O. Thompson, M.D., of the University of Illinois College of Medicine.

Tippecanoe County Medical Society members met on September twelfth at the Lincoln Lodge, in Lafayette. The speaker was Dr. James O. Ritchey, of Indianapolis, who spoke on "Some Problems of the Mediastinum." Forty members and guests attended the meeting.

On October tenth another meeting was held at the Lincoln Lodge, at which F. S. Crockett, M.D., F. T. Romberger, M.D., and G. A. Thomas, M.D., all of Lafayette, and Mr. Albert Stump, of Indianapolis, discussed medical services to the lower-income group. Two motions for the adoption of such a plan, and how it should be conducted, were made, which were followed by a discussion with recommendations for its organization and operation. Thirty-five members were present.

COUNCILOR DISTRICT MEETINGS

THE THIRD COUNCILOR DISTRICT MEETING

The Third District Medical Society members held an all-day session at the Silvercrest Hospital, in New Albany, on September twentieth. The follow-

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ing speakers appeared on the scientific and business program:

Lyman T. Meiks, M.D., of Indianapolis, who read a paper on "Clinical Aspect of Poliomyelitis with Emphasis on Diagnosis and Current Ideas of Treatment"; Jacob T. Oliphant, M.D., of Farmersburg, who spoke on "The Indiana Physicians Can Do the Job"; and Thomas A. Hendricks, of Indianapolis, whose subject was "A Preview of Important Subjects to Be Decided at the 1944 Annual Session of the State Association," followed by a report from Augustus P. Hauss, M.D., of New Albany, councilor of the Third District. After election of district officers the meeting was adjourned.

THE TENTH COUNCILOR DISTRICT MEETING

The Tenth District Medical Society members held their semi-annual meeting at Vogel's Restaurant in Robertsdale. This was a day-long session. The program consisted of a symposium on "Pencillin" and "A Clinical Demonstration of Wartime Care of the Sick and Wounded," by members of the Gardiner General Hospital medical staff, who brought with them several veterans who told of their experiences and treatment.

THE FIFTH COUNCILOR DISTRICT MEETING

The Fifth District Medical Society held a meeting on October tenth, in conjunction with the Vigo County Medical Society and the Western Indiana Dental Society.

The guest speaker was J. T. Oliphant, M.D., of Farmersburg, who spoke on "Legislative Problems." District officers were elected at the meeting.

THE ELEVENTH COUNCILOR DISTRICT MEETING

The Eleventh District Medical Society members met at the Elks Club, in Kokomo, for a business and scientific program on October twenty-fifth.

M. H. Draper, M.D., of Fort Wayne, opened the scientific program with a discussion of "Modern Concepts of Tuberculosis." Captain Archie E. Brown, of Billings General Hospital, spoke on "Tropical Medicine as It May Affect Future Civilian Life," and Gerald F. Kempf, M.D., of Indianapolis, presented "Uses and Limitations of Penicillin."

Preceding the scientific session there was a business meeting. Health insurance plans were discussed.

WOMAN'S AUXILIARY to the Indiana State Medical Association

OFFICERS FOR 1944-1945

President—Mrs. F. M. Gastineau, Indianapolis.
President-elect—Mrs. S. J. Petronella, East Chicago.
First Vice-president—Mrs. C. E. Munk, Kendallville.
Second Vice-president—Mrs. K. T. Knode, South Bend.
Third Vice-president—Mrs. Wayne Elsten, Lapel.
Fourth Vice-president—Mrs. R. G. Burman, Jeffersonville.
Recording Secretary—Mrs. L. L. Blum, Terre Haute.
Corresponding Secretary—Mrs. C. L. Bock, Indianapolis.
Treasurer—Mrs. A. W. Ratcliffe, Evansville.

CHAIRMEN OF STANDING COMMITTEES

Archives—Mrs. W. R. Morrison, Kokomo.
Bulletin—Mrs. Ernest O. Nay, Terre Haute.
War Participation—Mrs. Karl M. Koons, Indianapolis.
Finance—Mrs. Charles L. Wise, Camden.
Hygeia—Mrs. Otto H. Bakemeier, Indianapolis.
Legislation—Mrs. F. B. Wishard, Pendleton.
Press and Publicity—Mrs. Arthur B. Richter, Indianapolis, Chairman.
Mrs. Emmett B. Lamb, Indianapolis.
Mrs. J. W. Ricketts, Indianapolis.
Program—Mrs. E. N. Mendenhall, Fort Wayne.
Public Relations—Mrs. J. W. Mather, East Gary.
Councilor—Mrs. James W. Baxter, Jr., New Albany.
Parliamentarian—Mrs. Charles F. Voyles, Indianapolis.
Historian—Mrs. Harry L. Foreman, Indianapolis.
Pioneer Memorial—Mrs. O. G. Pfaff, Indianapolis.

Mrs. O. H. Bakemeier, *Hygeia* chairman, urges the members of the Woman's Auxiliary of the county medical organizations to recognize as one of its chief activities the promotion and distribution of *Hygeia*, the only authentic health periodical available in this country. Carry a copy with you to your P.T.A. meetings, club meetings, or any public gatherings you might attend. Let your slogan be, "Hygeia for Health."

CONVENTION NOTES

Mrs. James W. Baxter, Jr., presided at the board meeting on Tuesday afternoon, October 3, 1944. A report of the Finance Committee was read, and the only new business brought to the attention of the board was the motion made by Mrs. E. N. Mendenhall, of Fort Wayne, that one hundred dollars be allowed from the state treasury for convention expenses. This motion was passed. Mrs. Baxter, in her address, thanked the board members for their cooperation the past year, and advised a continuation of the present program.

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February 27-28 and March 1, 1945

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Mrs. John Carmack, registration chairman, reported that 145 members had registered by 6:00 P.M., October third. There were seventeen state officers and forty-six delegates present.

* * *

The main social event was a tea given in honor of Mrs. D. W. Thomas, Lock Haven, Pennsylvania, president of the Woman's Auxiliary to the American Medical Association. This was held on October third at 4:00 P.M., at the home of Governor and Mrs. Henry F. Schricker. Mrs. Schricker, Mrs. Thomas and Mrs. Baxter received the 165 guests. Mrs. G. W. Gustafson, president of the Marion County Auxiliary last year, and Mrs. C. F. Voyles, first president of the Marion County Auxiliary, presided at the beautifully-appointed tea table. Mrs. J. E. Holman, Sr., was in charge of the arrangements. Those assisting her were Mesdames J. E. Ricketts, Robert M. Moore, Russell R. Hippensteel, Ross C. Ottinger, Emmett B. Lamb, Russell Sage, and Harold M. Trusler. Miss Mary Spaulding, harpist, played during the tea hour.

* * *

Tuesday evening the doctors entertained their wives in the Murat Theater. The Frank Parrish and Harry Bason radio program was presented. Those that came early had the added feature of attending a Christian Science lecture!

* * *

Wednesday morning the annual breakfast was held in Block's tea room. One hundred sixteen guests were served. Following the breakfast the annual business session was held in the auditorium. Mrs. James W. Baxter, Jr., presided. Invocation was given by Rev. George S. Henninger. The Pledge of Allegiance was lead by Miss Florence Willard, a member of the Cadet Nurse Corps. Reports were given by all chairmen and county presidents.

Mrs. W. D. Thomas, our national president, addressed the group. She stated that the two projects of the auxiliary—Delinquency Problems and Physical Fitness—given them by the national association could best be accepted through the realm of the public relations program. She urged the development of understanding between the public and members of the medical profession to further both projects. "War always brings with it a general relaxing of customary standards, an attitude of 'don't care.' Juvenile delinquency is nothing more than the fruit which has grown from the seeds of parents' delinquency, education delinquency, and judiciary delinquency," Mrs. Thomas said.

She stated that there were four million child defectives in the United States, which is more than ten per cent of all children in the elementary schools. She listed physical defectiveness as one of the reasons for delinquencies.

"Never before has community recreation been so necessary," she pointed out. "Happy outdoor play is life in itself for children. It is the privilege of character-building agencies to participate in a crime-prevention program which will aid the youth to become good American citizens."

According to Mrs. Thomas, the planning of a physical fitness program began in July, under the direction of a joint committee of the American Medical Association and the National Council on Physical Fitness.

This program, through the support of industrial, social, religious and professional groups is to improve opportunities of the young men and women in the nation for gaining physical health.

The most important business was the amendment of Article V of the Constitution. The following report by Mrs. C. E. Munk, chairman of the Special Finance Committee, explains the change and the reason for it:

"The Special Finance Committee, composed of Mrs. Mendenhall, Mrs. Duemling, Mrs. Tinney, and myself was given the task of solving our financial problem. Our problem is the prompt remittance of national dues.

"It has been impossible for our state treasurer to

collect and send in the national dues before the deadline of March thirty-first. This puts us in a bad light, nationally. The national auxiliary requests that we make our fiscal year correspond with the national fiscal year. Our calendar year begins October first.

"Our dues are delinquent by March first, just five months after the beginning of our calendar year. It has been hard to impress upon our county treasurers the fact that they do not have the full year to remit dues. That is the situation we hope to remedy.

"These are our recommendations: We recommend that our calendar year start May first; and that we hold our annual Business Meeting just prior to May first.

"This business meeting would be called the 'Meeting of the House of Delegates.' At this time we would elect and install our officers. The annual reports of the county presidents, committee chairmen, and state officers would be given. Delegates to the national convention would be appointed. In short, all the business of the usual 'break-fast' session would be transferred to this 'Meeting of the House of Delegates.'

"The delegates would be appointed in the usual manner. They would receive with their credentials a copy of the recommendations of the nominating committee, and notice of any other important business. They should be instructed in voting by the county auxiliary they represent.

"There are a great many advantages in holding our annual business meeting before May first. It would put teeth in Section III, Article III of our by-laws, which says, 'Dues are delinquent March first.' The state treasurer could not accept dues after that date. She would need the intervening two months to close her books and prepare her annual report.

"The newly-elected president would have the opportunity of attending the national convention at the beginning of her term of office. That is the logical time for her to attend the convention, for it is there that she receives the instruction and inspiration to carry on her year's work.

"The committee chairmen would be appointed in May, and would have the summer months in which to prepare their programs for the year. The county units would then receive their programs at the beginning of their active season. Under our present system the active season of the county units is almost half over when they receive their programs and instructions from the state auxiliary. This is not the fault of the committee chairmen, but of the system under which they are serving.

"Now about the fall meeting: We recommend that we hold a meeting in the fall as usual, this meeting to be called the 'General Assembly.' By taking the business session away from this meeting we could have more inspirational, educational and social features than we have enjoyed in the past.

"We could have our national president with us at this time. We could have talks by our state president, by outstanding members of the medical profession, and perhaps by our national board members. We have many national committee chairmen who are well versed in the work they are doing, and it would be a pleasure and inspiration to listen to them. We have had some of these things in the past, but they have been too few and too short. We could have more social affairs than in the past, and have more time to enjoy them.

"The General Assembly would include the fall board meeting. If we hold a pre-House of Delegates and a post-House of Delegates board meeting, and a board meeting in conjunction with the General Assembly, it probably would not be necessary to call another meeting of the Board of Directors for the year."

Mrs. F. M. Gastineau was installed as the new president.

Following the business session, Mrs. Gastineau held a

(Continued on page xxiii)



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OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 37

DECEMBER, 1944

NUMBER 12

TUMORS OF THE BRONCHI*

PAUL H. HOLINGER, M.D.†

CHICAGO, ILLINOIS

Until recently, bronchial tumors were considered medical rarities. However, the increasing incidence of these tumors observed over the past few years makes it imperative to consider them in the differential diagnosis of any pulmonary disease. Inflammatory as well as neoplastic tumors may produce extensive pulmonary pathology simulating almost any disease of the chest, and consequently in questionable chest conditions it is important not only to listen to the chest from the outside with the stethoscope and look through it with x-rays, but also to look inside it with a bronchoscope to determine the exact nature and extent of the lesion.

The signs and symptoms produced by a bronchial tumor are usually due to the degree of bronchial obstruction it produces and to the degree of pulmonary suppuration which accompanies it rather than to the tumor itself. The usual symptoms are cough, wheezing, occasional hemoptysis, tightness in the chest, and in many instances chest pain. Acute bronchial obstruction often simulates lobar pneumonia with the cough, chest pain, fever, and even chills which may be associated with a sudden massive atelectasis of a lobe or an entire lung.

Inflammatory tumors of the bronchi consist of polyps, non-specific granulomas which may have arisen from the irritation produced by a foreign body, tuberculomas, and very occasionally some of the granulomas produced by fungus diseases. The diagnosis is made by physical and roentgen findings of bronchial obstruction, and by bronchoscopic observation. Confirmation is obtained from the histologic study of tissue removed from the tumor through the bronchoscope. Treatment consists of

a complete bronchoscopic removal by means of tissue forceps or electrocoagulation in order to re-aerate the lung distal to the tumor to restore function and prevent the development of bronchiectasis or lung abscesses which follow if the obstruction persists. In patients in whom the tumor has already produced these destructive changes, lobectomy or pneumonectomy may be the therapeutic procedure of choice.

Bronchial neoplasms have become increasingly common during the past decade. Aside from the fact that bronchoscopy forms a more integral part of the chest team now than formerly, and consequently a greater accuracy in the diagnosis of pulmonary diseases may be obtained, there is an actual increase in the incidence of this condition. This is reflected in vital statistics and in reports from institutions having large series of autopsies recorded over a period of years. The most alarming of these reports demonstrate that of the bronchial neoplasms, bronchogenic carcinoma alone has increased in frequency to become the second most common carcinoma in males, exceeded only by carcinoma of the alimentary tract. The present concept of diseases of the chest must be changed to accept this fact, and bronchogenic carcinoma must be placed high on the list of differential diagnoses to be considered in obscure pulmonary disease rather than at the end of the list as though it were a medical rarity.

The commonest benign bronchial neoplasm is the bronchial adenoma. This tumor is seen most frequently in women during the third and fourth decades of life. Its characteristic symptoms are an incessant, uncontrollable cough, asthmatic wheezing, occasional hemoptysis, especially during the menstrual period, and dyspnea. The physical findings of the chest demonstrate the presence of a unilateral wheeze, an obstructive emphysema or atelectasis dependent upon the degree to which the

* Presented before the General Meeting of the Indiana State Medical Association, at Indianapolis, on October 3, 1944.

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tumor has obstructed the bronchus. Chest x-rays may be negative if the tumor has not yet occluded the bronchus, or they may confirm the physical findings of obstructive emphysema or atelectasis. Bronchoscopically, the tumor is soft, smooth, bleeds freely, and may even be pedunculated. Occasionally it is pale and polypoid in appearance, but more often it is engorged because of the inflammatory process it has produced in the lung distal to its position in the bronchus.

A review of the literature shows that considerable difference of opinion exists as to the exact classification of bronchial adenomas. In rare instances cases have been reported that have had metastases. In other rare instances a tumor originally considered by biopsy to be an adenoma has later been shown to have been an adenocarcinoma, with the histologic picture characteristic of definite malignancy. However, the usual course of this tumor is that of slow growth locally, both intra- and extra-bronchially, with bronchial obstruction and its complication of pulmonary suppuration or hemoptysis as the principal pathology.

The treatment of bronchial adenomas depends upon the position and extent of the tumor locally, upon its histologic picture, and upon the degree of pulmonary suppuration in the affected lung. In many instances the tumor can be completely removed bronchoscopically by forceps, coring, or electrocoagulation. In other instances a lobectomy or pneumonectomy may be necessary because of local bleeding, extensive suppuration, or because of the extent of the tumor extra-bronchially.

Other benign tumors such as papillomas, chondromas, lipomas and osteomas may occur, but they are extremely rare. The diagnosis is made histologically by tissue removed through the bronchoscope. Treatment is dependent upon the location and extent of the lesion.

Bronchogenic carcinoma is the commonest of the malignant bronchial neoplasms. It is seen most frequently in men; in a series of 175 of our cases we have recently reviewed, there were 152 males and only 23 females, a percentage of 87 and 13, respectively. Forty-three per cent of these patients were in the fifth decade, and 72 per cent were between the ages of forty-five and sixty-four years. However, no age group is free of bronchogenic carcinoma; one child with a histologically-proved bronchogenic carcinoma was only six years of age.

Almost all primary carcinomas of the lung arise in bronchial tissue. A large number arise at or near the hilum, from the main bronchi or their primary divisions. Their size varies greatly from the large bulky tumors which cast large shadows in the lung field on roentgen films, to the small insignificant wart-like tumor which may escape detection by all clinical diagnostic measures, as well as on gross examination of the lung, post-mortem. The large tumors cause varying degrees of bronchial obstruction with bronchiectasis, lung abscess, or liquefaction necrosis of the lung beyond

the tumor. Mediastinal metastases with vascular stasis or laryngeal nerve paralysis may occur. The small tumors metastasize extensively through the lymphatics to all parts of both lungs or through the blood stream to every organ in the body. In such instances the secondary growths in the pleura, brain, bones, or kidneys may so dominate the clinical course of the disease that the original growth is entirely overlooked. Histologically, the squamous cell carcinoma is the commonest type of bronchogenic carcinoma. Sixty-four per cent of the series mentioned above were squamous cell tumors, 17 per cent small round cell tumors, 13 per cent anaplastic carcinomas, and 6 per cent were adenocarcinomas.

The four cardinal symptoms of carcinoma of the lung are cough, chest pain, expectoration, and dyspnea. The onset, however, is almost always insidious. Most patients complain of disorders referable to the respiratory tract, but frequently patients are unable to state the exact date of onset of symptoms. Cough, first non-productive and later productive and associated with occasional hemoptysis, is the commonest symptom. A vague chest pain or chest discomfort is another early symptom. Several patients described their early symptoms as due to a "spring cold," "summer cold," or "winter cold," depending upon the season during which the symptoms first appeared. In other instances bronchogenic carcinoma simulates pulmonary tuberculosis, with loss of weight, night sweats, cough, and hemoptysis. Occasionally the condition is first manifested as a severe, acute pneumonia, and recently many cases have been seen that have been observed for varying periods of time under the mistaken diagnosis of "atypical pneumonia."

Physical signs are usually absent in the early stages of bronchogenic carcinoma. A small peripherally-located growth may remain silent until metastases occur. Signs of tumors in the stem bronchi are due to bronchial obstruction, ulceration, infiltration, and secondary infection. Palpable supraclavicular, cervical or axillary nodes, a hemorrhagic pleural effusion, or evidences of bone, brain or liver metastases, or paralysis of the diaphragm or the vocal cords may be found.

The classical roentgen findings of bronchogenic carcinoma are those produced by varying degrees of bronchial obstruction. However, roentgen findings are exceedingly variable. An early tumor in a peripheral bronchus frequently manifests itself only by an area of localized "pneumonitis," which appears entirely inflammatory in character. If such a lesion clears and then re-occurs, the probability that it is due to a neoplasm is great. Areas of pulmonary suppuration, such as bronchiectasis or lung abscess or atelectasis of a lobe or an entire lung in a patient of any age, must be considered in the light of a possible pulmonary neoplasm, roentgenologically.

The diagnosis of bronchogenic carcinoma is dependent upon the microscopic examination of tissue

removed from the tumor or its metastases. In approximately 80 per cent of the series of 175 cases mentioned above, a positive biopsy was obtained bronchoscopically from the tumor itself. Symptoms and findings indicating that a bronchoscopic examination should be made are suggested by the symptomatology, and physical and roentgen findings noted in the foregoing discussions. Such symptoms as a persistent cough, a wheeze, an unexplained hemoptysis, a recurring or unresolved or "atypical" pneumonia are all specific indications for bronchoscopy. However, all too frequently such indications are ignored and this examination, which can be done as a routine examination with local anesthesia, is postponed or not considered. Often the prolonged, ineffective use of chemotherapy is responsible for delaying bronchoscopic investigation of obscure pulmonary disease. This is significant because early diagnosis of a bronchogenic carcinoma can permit surgical removal of the lung to cure this otherwise hopeless condition. It is significant, too, from this standpoint, that in our series of 175 cases of bronchogenic carcinoma more than six months elapsed from the onset of symptoms until a bronchoscopic examination was made in 86, or approximately 50 per cent, of the cases, and in 14, or eight per cent, more than one year elapsed.

The primary purpose of the bronchoscopic examination is to establish accurately the diagnosis through the biopsy. Just as important is the determination of operability or inoperability through interpretation of various other findings, such as the motility of the vocal cords, the character of the carina, the position of the tumor in relation to the bifurcation, and the extent of invasion of the tumor along the bronchial walls proximal to the actual point of bronchial obstruction. A bronchogenic carcinoma is considered inoperable if mediastinal metastases are present as evidenced by vocal-cord paralysis or carinal thickening or rigidity. It is likewise considered inoperable if the tumor reaches the carina since this leaves no stump for bronchial closure.

The treatment of bronchogenic carcinoma is primarily surgical. The tremendous strides made during the past ten years in thoracic surgery present an increasing challenge to find operable cases early. The hazard of the pneumonectomy operation has been greatly reduced. Other forms of therapy, except in extremely rare instances, are of little, if any, value. The disproportion that exists between the large number of reported cases of primary carcinoma and the small group that has been successfully treated is not the fault of the surgeon. It is due to the failure to recognize the case early so that the bronchoscopic examination and the extirpation of the lesion by a pneumonectomy can be done before metastases develop.

SUMMARY

Bronchial tumors produce an interesting series of findings usually dependent upon varying degrees of bronchial obstruction. Their incidence is increasing both actually and because more frequent routine bronchoscopic examinations in chest institutions demonstrate their presence. Inflammatory tumors such as polyps are rare, but granulomas and tuberculomas are not uncommon. Both benign and malignant neoplastic tumors are seen. Of the former, the commonest are the bronchial (or pulmonary) adenomas, and papillomas, while of the latter, bronchogenic carcinoma is the outstanding and most frequent of all bronchial tumors. The symptoms, and physical and roentgen findings, of all bronchial tumors are similar. A persistent cough, a wheeze, an unexplained hemoptysis, a recurring or unresolved or "atypical" pneumonia are all suggestive. The bronchoscopic examination in such cases is imperative, and the diagnosis may be established from tissue removed directly from the tumor. The therapy of the benign bronchial tumors is bronchoscopic removal or cauterization, or a lobectomy or pneumonectomy if the tumor is too large for the more conservative procedure. The therapy for the malignant bronchial tumors is surgical resection, if the patient is seen at the onset of his symptoms when the tumor is still operable.

ABSTRACT

PENICILLIN FAILURES

"Penicillin failures," Arthur L. Bloomfield, M.D., William M. Kirby, M.D., and Charles D. Armstrong, M.D., San Francisco, say in *The Journal of the American Medical Association* for November 11, "for the most part fall into the following groups: cases in which the treatment is too brief or the daily dose too small; cases in which penicillin fails unless surgical drainage is also done; overwhelming infection, even with a sensitive strain [of the invading organism]."

SEPTICEMIA IN NARCOTIC ADDICTS

Pointing out that the development of bacterial infection

of the blood stream in narcotic addicts as a result of their addiction is a rare occurrence, four Washington, D.C., physicians tell in *The Journal of the American Medical Association* for October 28 of five cases of such infection in heroin addicts. In four of the five cases death followed the development of acute bacterial endocarditis, with three of the cases due to *Staphylococcus aureus* and the fourth to *Bacillus pyocyaneus*. In the one case of *Staphylococcus aureus* septicemia without endocarditis, recovery occurred. Hugh Hudson Hussey, M.D.; Thomas F. Keliher, M.D.; Bertram F. Schaefer, M.D., and Bernard J. Walsh, M.D., report the cases.

FIBROCYSTIC DISEASE OF THE PANCREAS WITH AN UNUSUAL ASSOCIATED LESION

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ELKHART

The comparatively few authentic cases of fibrocystic disease of the pancreas reported would lead one to believe that the condition is rather uncommon, yet with the increased number of cases now being reported it is quite obvious that the disease has too often been unrecognized, rather than uncommon.

The case herein reported is one which has been closely observed in prenatal life, birth, infancy, childhood, and finally at autopsy. The patient was seen by more than one reputable pediatrician and spent four months in a children's hospital. The celiac syndrome was recognized, but the "pulmonary complication" was so predominant that more attention was directed toward the interpretation of this lesion.

It was not until our roentgenologist,** after many x-ray studies of the lungs over a period of time, associated the pulmonary changes as a common finding in this disease.

Family History

A careful survey of the family history was made because of the recognized tendency for this disease to occur in more than one member of a family. There were only two siblings whose history might be construed as suggestive but certainly not conclusive. One died at fifteen months. Spasms occurred at three months. At six months a diagnosis of whooping cough was made, and the cough continued throughout life. Weight at death was ten to twelve pounds. The child was mentally deficient. The second child, who was always much undernourished and fatigued, died at the age of seven years, the cause given as appendicitis. There was no operation or autopsy. The mother is an offspring of a consanguineous marriage (first cousins).

The mother is now pregnant, four months duration. She is just recovering from a rather stormy toxemia, quite similar to that which occurred in the previous pregnancy. The outcome of this gestation will be observed with keen interest.

Case Report:

D. W.—Aged four years, female.

The child weighed four pounds at birth. She was six weeks premature. The mother had a normal spontaneous delivery. Breast feeding could not be mastered, and she was fed on S.M.A. milk formula by pipette. Gain in weight was only fair. Stools seemed more frequent than normal. After several weeks she was put on Protein S.M.A. formula.

Nutrition and digestion improved, with gradual gain in weight and less frequent stools. At three and one-half months she was put on evaporated-milk formula. She gained weight but continued to have frequent stools, and not infrequent vomiting seizures.

At fifteen months, she developed a respiratory infection and was hospitalized. The case was diagnosed as bronchial pneumonia. After this infection cough was a persistent symptom throughout her life. It was most marked early in the morning, and was often associated with vomiting and expectoration of very large amounts of tenacious mucus. After such experiences she would take food throughout the remainder of the day. There was a copious nasal secretion throughout her life. The mother states that the patient was seldom entirely free from nasal discharge and cough.

The bowel habit was irregular. The quantity was enormous and foul smelling. When the patient suffered from diarrhea, a low fat diet, skimmed milk, et cetera, improved the situation.

The mother noted a marked tendency for the child to develop a "pot-belly" out of all proportions to the general body frame. However, there were periods when the abdomen appeared quite normal.

Periodic fever was persistent, ranging from 100 to 102 degrees, and occasionally higher. At such times the child appeared sick; she would not eat; cough became more marked; fatigue became more apparent, and she sought bed rest. During the intervals when she was afebrile, she was quite active, though easily fatigued. The condition persisted with exacerbations and remissions. The child attended kindergarten and was said to be above the average in intelligence.

In June, 1943, the writer advised the parents to have the child hospitalized to facilitate more detailed study and observation of the case. She was admitted to a children's hospital on June 18, 1943. The report from the children's hospital follows:

"At the time of admission there was a mucopurulent material in her throat. Her breast was somewhat of a pigeon-breast type. There was no dullness found and no rales were heard, the heart was negative, blood pressure 120/70. The liver was palpable two fingers below the costal border. The reflexes were slightly hyperactive. The fingers and toes were clubbed. She had a severe cough. Urinalysis was essentially negative. The hemoglobin was 10.5 gms., white blood count 4,800, with 4 per cent bands, 65 per cent adult polys, and 27 per cent lymphocytes. At one time

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her white blood count rose to 8,200, with an essentially normal differential. Her sedimentation rate at the time of admission was 36 and later 22. The Mantoux test was negative for acid-fast bacilli. Neither was any yeast-like fungus found. Agglutinations for typhoid, paratyphoid, and undulant fever were all negative. The Schick and first and second strength Mantoux tests were negative. The TNP was 24. Forty-eight-hour stool specimen for fat showed a total of 58 per cent (normal 15-25 per cent), 19 per cent neutral fat (normal 1-2 per cent), fatty acids 31 per cent (normal 9-13 per cent). Duodenal aspiration was done and amylase and trypsin were present. Lipose was negative but there was an insufficient quantity to check the examination. A glucose tolerance test was done, and the fasting blood-sugar was 70 and rose to 154. At the end of the test the curve had fallen sharply to the level of 54. X-ray examination of the chest at the time of admission showed fibrotic changes involving all of the right lung and most of the left. Later films showed an accentuation of the interstitial markings throughout both lung fields. A lipiodol injection was done, and there was no definite evidence of bronchiectasis. X-ray examination of the sinuses revealed dense clouding of all sinuses.

"Shortly after admission the patient had a daily temperature as high as 104.5 degrees and was acutely ill. Fine rales were heard in both lungs after coughing, and the patient was treated with sulfathiazole for a few days. Gradually she recovered from this acute episode but continued to cough occasionally and had a temperature up to 100 degrees. Her condition was static for some time, and then it was noted that she had large very foul stools. At this time the stool and enzyme examinations were done. In view of these findings she was put on a protein paste and banana diet and given intramuscular injections of liver extract and vitamin B daily. Gradually her diet was increased until at the time of her discharge she was able to take a low fat, soft diet. The parents stated that they were moving to Arizona, and we thought that there might be a possibility that the change in climate might prove beneficial. Our final diagnosis on the case was chronic interstitial pneumonia and celiac disease."

She was returned home on October 13, 1943. She was extremely emaciated but ambulatory. The child did not progress favorably, cough became persistent, bowel movements were more frequent, weight loss was more marked, and emaciation was pronounced. Anorexia became more marked, and her fever was elevated and persistent.

She was again hospitalized for observation at the local hospital on November 11, 1943. During this hospitalization the digestive symptoms became more pronounced, and the patient was less willing to accept nutrients. Often diluted fruit juices and water were the only nourishment. Despite these facts the patient remained alert although she was

extremely restless. Her voice remained fairly strong.

A blood transfusion (300 cc.) was given on the fourth day at the hospital, and there was an improvement in her general condition. On the seventh day of hospitalization her condition suddenly became alarming. There was every evidence of a severe and massive hemorrhage. She appeared to be in extremis; her pallor was marked; respiration was very rapid and labored; pulse was imperceptible; extremities were cold and clammy—all these gave evidence of shock and hemorrhage. Following this change in symptoms the patient was given another transfusion, which resulted in an improvement in her condition. Several other transfusions were given at frequent intervals. The hemorrhage appeared to be from the intestines as the stools were voluminous and contained large amounts of dark and bright red blood.

From this time on the child began to take nourishing liquids and low fat diet. All through her hospital stay, pain in the right hypochondriac region was a prominent symptom. The pain would come on periodically and was colicky in nature. Food or liquids seemed to relieve this distress, and the child would ask for food more for this reason than a sense of hunger.

All other symptoms continued, and she became more and more malnourished. On December 10, 1943, while sitting on the bed pan, she collapsed and died from acute cardiac failure and anoxemia.

Laboratory Findings

Blood—Numerous complete blood counts and cell determinations established the diagnosis of a secondary anemia. A leucocytosis ranging from 12,000 to about 25,000 was constantly present from the onset of the pneumonia at the age of fifteen months until death of the patient. One report from the children's hospital, however, reported the presence of 4,000 white blood cells. The coagulation time was 1½ minutes; bleeding time was 2½ minutes.

Bronchial secretion—Typing for pneumococcus was negative. Bacteriological examination revealed: gram negative cocci, streptococci, staphylococci, and a diphtheroid form.

Spinal fluid—Trace of globulin and a cell count of 3 per cc.

Blood-sugar—Tests were made routinely during the last few weeks of life. Results were within the normal range.

Stool examination—Early examination of the stools were negative for the presence of occult blood. The stool contained an excessive amount of fat at all times. No parasites were found.

Urine—Examinations showed a moderate albuminuria.

Prothrombin level was 93 per cent.

Duodenal contents were not examined during the last few weeks of life.

Roentgenological studies showed evidence of an interstitial pneumonitis with progressive changes. Numerous follow-up films of the lungs showed

increased interstitial changes as the case progressed.

Treatment

Varied medications were given the patient before the diagnosis of fibrocystic disease was made. The treatment was given for alleviation of a nutritional deficiency.

Autopsy*

Gross Pathology

Pancreas: The portion of the pancreas at the duodenal border was an ovoid mass measuring about 10 cm. in width and 8 cm. in thickness. The surface was pale yellow in color and covered by small adhesions loosely attached to the surrounding viscera. The pancreas was firm. The cut surface was pale yellow with minute areas of darker yellow color, containing a small amount of pale yellow secretion. The pancreatic duct was patent and could be probed for one inch or more. The remaining portion of the pancreas appeared quite normal.

Lungs: The lungs completely filled the chest cavity. There were some fine adhesions to the plural surface. A few cc. of serosanguinous fluid was found in the pleural cavity. The lungs were quite normal in color and appeared emphysematous. Upon sectioning the lung, the bronchi, and the trachea appeared filled with a thick suppurative exudate.

Gastro-intestinal Tract: Upon opening the duodenum at its antimesenteric border, the pancreatic tumor mass appeared to invaginate into the lumen; at the summit of the mass there was a duodenal ulcer measuring about 3 cm. in diameter and about 2 mm. in depth with indurated margins. The floor of the ulcer was greyish and necrotic. There was nothing remarkable about the rest of the gastro-intestinal tract. It showed no noteworthy changes except the very thin-walled large bowel. The duodenum contained ten to fifteen cc. of thick tenacious yellow material.

Liver: The liver was enlarged and extended ten to twelve cm. below the right costal border. The color was mottled, suggesting degenerative changes. The surface was smooth and its consistency appeared normal.

Kidneys: The kidneys showed evidence of moderate cloudy swelling.

Sections of tissues were sent to the South Bend Medical Laboratory for examination.[†] The report follows:

"The following are the outstanding features of the pathologic anatomy found at the post-mortem examination.

"Both lungs show multiple areas of atelectasis, and the bronchi contain a thick mucoid purulent

exudate. On section there is seen multiple patchy areas of consolidation.

"Just below the pyloric valve there is an area of ulceration measuring 2 cm. in diameter. The ulcer is covered by recent blood clots, and the base of the ulcer is formed by the underlying pancreas. The remaining organs show no gross abnormalities. Section of the pancreas reveals the ampulla of Vater to be patent. Serial sections were taken at different points from the head to the tail of the pancreas.

"The outstanding feature of the microscopic examination of the pancreas showed the ducts and acini to be filled with varying amounts of coagulated eosin-staining secretion. The epithelium-lining cells were flattened, and in many areas the contents of the acinus is filled with laminated concretions. There appears to be a definite increase of the lobular connective tissue, and scattered throughout there are found varying foci of round-cell infiltration.

"The Islands of Langerhans appear to be intact and normal in number. Microscopic examinations of the lungs and bronchi reveal a lesion to be essentially that of a suppurative bronchitis and bronchiectasis with patches of bronchopneumonia. The purulent exudate found in the lumen of the bronchioles and alveoli is also found to contain colonies of bacteria."

Comment:

"From the pathological standpoint, the presence of a duodenal ulcer represents the first description of such a lesion in this group of cases. It is surprising that an ulcer of the duodenum does not appear more frequently; inasmuch as there is a lack of pancreatic secretion the acid contents of the stomach may play a part in the duodenal ulceration. This fact has been well demonstrated by Mann and Williamson."

Discussion and Summary

From the clinical analysis of Anderson,¹ and of Blackfan² and May, it appears that the infants in whom obstructive lesions of the pancreas are found at autopsy may be divided into three clinical groups:

1. Those who die in the first week or a few weeks of life usually of meconium ileus.
2. Those who die usually in the first year of life with a clinical history of nutritional disturbance often obscured by respiratory disease, usually called chronic pneumonia, bronchitis, or bronchiectasis.
3. Those with symptoms recognizable as pre-celiac and celiac disease who die of respiratory disease at an age of one to fourteen years of age.

¹ Anderson, D. H.: Cystic Fibrosis of the Pancreas and Its Relation to Celiac Disease, *Am. J. Dis. Child.*, **56**:344, 1938.

² Blackfan, K. D., and May, C. D.: Inspissation of Secretion, Dilatation of Ducts and Acini; Atrophy and Fibrosis of Pancreas in Infants; Clinical note, *J. Pediat.*, **13**:627-634, (Nov.) 1938.

* R. G. Horswell, M.D., and the writer conducted the autopsy.

[†] Gross and microscopic studies were made by A. S. Giordano, M.D.

This case belongs to the latter group and possessed the clinical features similar to those of true celiac disease, and occurring in this sequence: early nutritional disturbance; frequent bulky, foul-smelling stools containing an excess of fat; distention of the abdomen; and wasting of the extremities more than of the face. At fifteen months there was added the symptom of pulmonary disease, not typical of celiac disease, and which remained the predominant and persistent clinical manifestation which apparently caused death.

There was one other noteworthy clinical and pathological feature—sudden massive hemorrhage from the bowels, the result of a large superficial duodenal ulcer opposite the summit of a well-defined firm pancreatic mass, involving the greater portion of the pancreas, and which had invaginated itself into the wall of the duodenum.

We may recall in the history of this case that a duodenal aspiration was done, the comment being "The enzymes were deficient but the volume was insufficient to check." The small volume alone is suggestive of one point of diagnostic value. Andersen³ has pointed out the importance of patience in these cases in order to obtain sufficient contents for the enzyme tests. As long as four hours with the tube in the duodenum may be necessary.

It is well to note that in 2800 routine post-mortem examinations in infants, Blackfan and May² found definite evidence of this pathological entity in thirty-five cases. It is quite evident then that without autopsy many escape recognition, especially early in life. Fortunately, for diagnosis the examination of the duodenal contents gives definite evidence of this disease at its very onset.

Sidney Farber⁴ in his article "Pancreatic Function and Disease in Early Life" has given such an excellent survey on this that the writer quotes in part from his summary:

"The determination of pancreatic enzyme activity in the duodenal content permits accurate differentiation of the form of celiac syndrome caused by pancreatic fibrosis from all other forms of the celiac syndrome, including idiopathic celiac disease, and furnishes a means of ascertaining the presence of pancreatic achylia and pancreatic fibrosis in patients who suffer from malnutrition and upper respiratory disease, but who do not exhibit the clinical features of the celiac syndrome. . . ."

"No diagnosis of idiopathic celiac disease, idiopathic steatorrhea, nontropical sprue, pancreatic fibrosis or other similar diseases should be considered established until the pancreatic enzyme

activity of the duodenal drainage has been measured."

The etiology of this disease has not been elucidated. If this could be established, we could possibly institute more adequate therapy or prevention.

There is evidence supporting the view that it is a congenital obstruction of the pancreatic ducts. Some authorities⁵ contend that it is an abnormal thickening of the physical character of the acinar secretion, which becomes inspissated, causing obstruction with resulting hypofunction of secretory mechanism, initiating a vicious circle.

We may also consider the exciting cause of a hormone deficiency, one whose function it is to stimulate these same cells to produce a normal enzyme. If such a deficiency exists certain structural changes, which the pathologist rather consistently finds in the more advanced cases, might be the result of atrophic changes due to a functionless pancreas. It would seem plausible that we should get better results, clinically, by introducing pancreatic enzymes into the gastro-intestinal tract, but we know it is only supportive in a very meager way.

Other authors⁶ offer the fact that metaplasia of the bronchi, pancreatic ducts, and occasionally other organs so often an associated pathological feature indicate vitamin A deficiency as a cause.

It may be that the metaplasia is due to a vitamin A deficiency, the deficiency not being the cause but the result of the infant being incapable of assimilating Vitamin A. Under these conditions the respiratory system becomes especially vulnerable to a suppurative infection.

In observation of this case clinically, and in the general pathological aspect, one cannot readily discard a possible inflammatory lesion as the causative factor. The view has been advanced by others but has not been given credence by the pathologists who maintain that the fibrosis, which is so consistently present, is one of replacement fibrosis rather than an inflammatory one. No demonstrable organism has been isolated as an exciting cause; neither has it been possible to reproduce any similar pathological changes by animal inoculations. This does not disprove the possible existence of a filterable virus which may inhibit or disturb the secretory function of cells normally capable of producing the essential pancreatic enzymes.

Can we not assume that the fetus, while in utero, develops normally and is born without evidence of nutritional or physical abnormalities, but at the moment it is separated from the maternal environment the pancreas must function to sustain life? Pathologically, it is difficult to detect any changes in the pancreas at this early date. If we can presume, however, that there is a congenital absence or deficiency of a pancreatogenic substance or

³ Anderson, D. H.: Pancreatic Enzymes in Duodenal Juice in the Celiac Syndromes, *Am. J. Dis. Child.*, **63**:643, (April) 1943.

⁴ Farber, Sidney; Shwachman, Harry, and Maddock, Charlotte L.: Pancreatic Function and Disease in Early Life. 1. Pancreatic Enzyme Activity and the Celiac Syndrome, *J. of Clin. Investigation*, **22** No. 6, 827-838, (Nov.) 1943.

⁵ Blackfan, K. D., and Wolbach, S. B.: *J. Pediat.*, **3**:679, 1933.

⁶ Anderson, D. H.: Cystic Fibrosis of the Pancreas in Brennemann, J.; *Practice of Pediatrics*, W. F. Prior Co., Inc., Vol. 1, Chap. 29, pp. 11-16, 1941.

hormone which is essential for activating these cells, we can, I believe, follow the clinical and pathological train of events. Those infants who die very early in life have complete pancreatic achylia incompatible with life, while those that go on for weeks or longer have proportionate deficiencies giving the clinical and pathological picture of the case reported.

Since the original presentation of this case before the staff, this mother was again delivered on August 28, 1944, by section at seven and one-half months gestation. A sudden severe intra-uterine hemorrhage, due to accidental separation of the placenta, made this imperative. Death of the fetus was evident but viability was present prior to this complication.

Birth weight was 4 pounds and 2 ounces, and the offspring appeared normal for this age.

The pathologist reported the placenta without noteworthy lesion.

Autopsy on the fetus revealed no gross abnormalities, and microscopic section of the pancreas "revealed the tissue to be of uniformly normal structure."

These autopsy findings, of course, establishes no factor of etiological significance because we have no reason to presume the case would have developed fibrocystic disease.

However, we did have an identical neonatal course with the exception of the placental accident and the type of delivery.

In my review of the literature^{7,8,9,10,11,12,13,14,15,16,17} I do not recall any pathological reports which definitely established fibrocystic disease of a fetus in utero or of stillborns.

The point I wish to present is that these infants

who subsequently develop this lesion may have normal pancreatic tissue histologically until the advent of self-function at birth manifests its secretory dysfunction, and it is from this time that pathological changes first become evident and progressive.

Whatever the etiological factors are, the pathological changes are essentially incompatible with life under our present knowledge of the disease.

⁷ Anderson, Dorothy H., and Early, Marialuise V.: Method of Assaying Trypsin Suitable for Routine Use in Diagnosis of Congenital Pancreatic Deficiency, *Amer. J. Dis. Child.*, **63**:891-893, 1942.

⁸ Beazell, J. M.; Schmidt, C. Robert, and Ivy, A. C.: The Diagnosis and Treatment of Achylia Pancreatica, *J.A.M.A.*, **116** No. 25, 2735-2739, 1941.

⁹ Comfort, Mandred W.: Tests of Pancreatic Function, *J.A.M.A.*, **115** No. 24, 2044-2050, 1940.

¹⁰ Daniel, W. A., Jr.: Fibrocystic Disease of the Pancreas, *Am. J. Dis. Child.*, **64**:33-42, 1942.

¹¹ Hanes, Frederic M., and McBryde, Angus: Identity of Sprue, Nontropical Sprue and Celiac Disease, *Archives of Internal Medicine*, **58**:1-16, 1936.

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ABSTRACT

FIND GONORRHEA CAN BE CURED AS EASY IN WOMEN AS IN MEN

The cure of gonorrhea with sulfonamide compounds and penicillin is as easy in women as in men, despite widespread beliefs to the contrary, Ruth Boring Thomas, M.D.; William E. Graham, M.D., and George R. Cannefax, of the United States Public Health Service Medical Center, Hot Springs, Arkansas, report in *The Journal of the American Medical Association* for November 4 as a result of studies carried out at their institution.

In two hundred Negro women 90 per cent passed the tests of cure after one course of treatment, chiefly with sulfathiazole, and 95 per cent after two courses. In three hundred fifty-five white women 60 per cent passed tests of cure after one course of treatment and 70 per cent after two courses.

"These results," the three investigators say, "correspond closely to those recently reported with both Negro and white men in the Army. The evidence presented here indicates that under controlled conditions the bacteriologic cure of gonorrhea with sulfonamide compounds is as readily brought about in women as in men. This is true also for penicillin."

The authors point out that although the number of women with gonorrhea who have been treated with

sulfonamides may run into the millions there have been few reports of results in groups of patients under proper treatment control. Their present report deals with women domiciled in an institution during the entire course of treatment and who were not released until tests indicated they were cured.

Another important finding was that the Negro is easier to cure of gonorrhea than a white person. This concurs with other findings. The first course of treatment of five days produced 60 per cent cures among the white women and 90 per cent among the Negroes; after the second course of five days the cures were 27 per cent among the white women and 53 per cent among the Negroes.

"An explanation of the difference in response to sulfonamide therapy between Negro and white patients must await the results of further investigation," the investigators say.

Most of the patients received sulfathiazole. Those found sulfonamide resistant were given other types of treatment. When penicillin became available it was used for these types of cases.

GONORRHEAL OPHTHALMIA

Report of a Case Treated with Penicillin

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An acute gonococcic conjunctivitis can provide one of the most-rapidly destructive clinical pictures in ophthalmology. Although the gonococcus¹ may on occasion give rise to a mild catarrhal conjunctivitis or, rarely, to a pseudomembranous inflammation, the typical reaction is purulent. It is characterized by an acute conjunctival inflammation, great swelling of the lids, copious production of pus, and a marked tendency to corneal involvement. Considering the prevalence of gonorrhea, infection of the conjunctiva fortunately is not common—one in seven or eight hundred cases.

The disease is ushered in by a bright red velvety appearance of the mucous membrane, a watery discharge, and a tense edematous swelling, especially of the upper lid. Pain is often intense, and the eye is very tender to touch. The discharge, at first sanious, then pus-flecked, becomes abundant and frankly purulent after about five days. The eye literally pours pus. In the adult the fully developed case of gonorrheal conjunctivitis rarely escapes without some corneal involvement, and often the eye is hopelessly ruined therefrom. Marginal ulcers are most often found in the pus-filled trough formed by the chemosis, and may coalesce and form a ring ulcer. One may see a small central ulcer which is deeply burrowing and rapidly perforating. Not uncommonly, large central areas rapidly necrose and deep ulcers are formed, usually perforating with disastrous results. Other complications are less common and are usually seen as iritis, cyclitis, and hypopyon.

With the advent of sulfonamides, a new approach in the treatment of gonorrheal ophthalmia was graciously received. Fewer complications, more rapid healing, and quicker subjective relief was the rule. Intensive local therapy, however, is imperative, and must be constant and unremitting day and night. Considerable relief is obtained from pieces of gauze kept soaked in ice and water and laid lightly over the eye, changing them every few minutes for half an hour, and repeating this every two or three hours. When pus appears its stagnation must be prevented by repeated bathing of the eye every hour or half hour both day and night. A shield affixed over the non-infected eye at the earliest possible moment is the most important

single factor in the management of a unilateral case.

The availability of penicillin with its remarkable effectiveness against the gonococcus may afford a still better approach in the treatment of this disease entity. Clinical evidence has not yet been sufficiently compiled to completely evaluate the effects of this treatment. Recent reports in the literature have, however, been very encouraging. Penicillin has been found valuable in eye disease caused by the pneumococcus, gonococcus, streptococcus hemolyticus, staphylococcus, and Streptococcus viridans. It can be given parenterally or locally or by both methods simultaneously. Griffey² reported the treatment of a case of gonorrheal conjunctivitis with penicillin sodium. His therapy consisted of intramuscular injections of 25,000 units of the drug every three hours for a total of ten injections. The case involved was one in which gonorrheal conjunctivitis had existed for over six weeks and had resisted all other forms of treatment. He reports that within ten hours after the beginning of penicillin therapy the exudate of the eye had greatly diminished. He states that cultures of the conjunctival secretion for *Neisseria gonorrhea* were persistently negative five hours after the institution of penicillin therapy. His patient made an uneventful, complete recovery. Dr. Griffey used nothing but 1 per cent atropine locally in the affected eye.

Cashell³ states that "both calcium and sodium penicillin salts are efficacious and well tolerated by the eye in drops or in ointment containing 500 Oxford units per cc." In our experience penicillin ophthalmic ointment (Penicillin ophthalmic ointment made in our own laboratories from base obtained from a pharmaceutical concern. Each gram of ointment contains 500 Oxford units penicillin.) has notably controlled purulent conjunctivitis in a number of cases, especially those produced by *Streptococcus viridans*, beta hemolytic streptococcus, *Staphylococcus aureus*, and several in which no organisms were isolated.

Report of Case—No. 14648

Admitted to United States Public Health Service Hospital, July 18, 1944.

Discharged on September 1, 1944.

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¹ Duke-Elder, Sir W. Stewart: *Text Book of Ophthalmology*, Vol.2, page 1563.

² Griffey, Walter P.: Penicillin in Treatment of Gonorrheal Conjunctivitis, *Archives of Ophthalmology*, 31:162, (Feb.) 1944.

³ Cashell, G. T.: Treatment of Ocular Infections with Penicillin, *British Medical Journal*, 1:420, (March) 1944.

FIGURE
No. I

Note the marked edema of both the upper and lower lids, as well as the profuse purulent discharge pouring down over the patient's cheek.

FIGURE
No. II

Examination of the cornea, bulbar conjunctiva and lids was carried out with difficulty due to the edema and the pain in the eye. The bulbar conjunctiva was injected and edematous, and the cornea appeared cloudy. The tarsal conjunctiva was thickened and highly injected.

- Diagnosis: 1. Gonorrheal urethritis.
2. Gonococcal conjunctivitis, right eye.
3. Keratitis, purulent, right eye, due to gonococci.

History—On July eighth, ten days prior to admission, the patient had intercourse. Four days later, July twelfth, he noticed a slight penile discharge, but disregarded it. On July sixteenth he developed a haziness of vision and a discharge in his right eye. By the following evening pus poured from his eye, and the lids were so edematous he was unable to open the eye. He was admitted to the hospital on the evening of July eighteenth, complaining of profuse discharge and pain in the right eye.

Examination—Patient is a well-developed, white male, aged sixteen, acutely ill, suffering great discomfort and pain in his right eye. Examination revealed a marked edematous condition involving both the upper and lower lid of the right eye. (Figure 1.) A thick, profuse, whitish-yellow, purulent exudate literally poured from the right conjunctival sac. (Figure 2.) The bulbar conjunctiva was injected and highly edematous, the whole of the cornea appeared cloudy, and the pupil was small. Examination was carried out with difficulty due to the extreme edema and pain in the eye. The tarsal conjunctiva was highly injected and thickened. The left eye was essentially negative. A thin, purulent discharge was noted from the penis. The rest of the examination was not significant.

Course and Treatment—The patient was placed on complete bed rest with continuous private nursing care. Local therapy to the involved eye was intensive and consisted of ice compresses, repeated saline irrigations, 1 per cent atropine in sufficient amount to keep the pupil dilated. Penicillin ophthalmic ointment was instilled in the conjunctival sac every two hours. A transparent shield was kept continuously over the uninvolved eye. Aseptic conditions were maintained at all times. Smears taken from the eye on admission were negative for the gonococcus, but a culture was positive. Smears and cultures from the urethral discharge were positive for the gonococcus. Penicillin, 100,000 units divided equally into six doses, was given daily, intramuscularly, for eight days. The profuse purulent discharge decreased markedly within

forty-eight hours after the intensive therapy was started. However, an opacity involving the entire lower half of the cornea developed the second day after admission. The central portion of the opacity broke down, an ulcer developing, which stained with fluorescein. The urethral discharge ceased within three days and did not recur any time during the course of the patient's hospitalization. After the sixth day of hospitalization, no purulent discharge was noted from the eye. The ulceration of the cornea improved daily and appeared completely healed by August 1, 1944. The residual scar measured 2 millimeters horizontally, and between 1 and 2 millimeters vertically. Slit lamp examination showed the opacity to involve only the superficial layers of the cornea. The first negative eye culture was obtained on July 26, 1944. Repeated cultures on July 30, 1944, August 2, 1944, and August 10, 1944, also were negative. The eye was clinically negative by August 24, 1944, and 1 per cent dionin solution was instituted in an effort to hasten absorption of the scar in the cornea. The patient's vision on August 31, 1944, was 20/20 both eyes. (Figure 3.) He was discharged from the hospital on September 1, 1944, clinically cured, with no disability from his illness except for some slight narrowing of his peripheral vision in the lower field.

We are uncertain as to just what effect the penicillin ophthalmic ointment used on our patient may

¹ Von Sallman, L., and Meyer, K.: Penetration of Penicillin Into the Eye, *Archives of Ophthalmology*, 31:1, (January) 1944.



FIGURE No. III

The eye as it appeared on September 1, 1944, the day of discharge from the hospital. (Figures 1, 2, and 3 are reproduced in reverse, the right eye being the one involved.)

have had on the course of the disease. We believe that it did play a part in the ultimate recovery. Von Sallman,⁴ Cashell, mentioned previously, and others have proved the effectiveness of penicillin applied topically to the eye in certain conjunctival infections.

CONCLUSION

Definite conclusions as to the complete effectiveness of penicillin therapy in the treatment of gonorrheal ophthalmia will require a large series of cases and more detailed study. However, in the case reported, a definite clinical response was

rapidly obtained. The profuse purulent exudate was markedly decreased within forty-eight hours, and completely eliminated within five days. An eye culture obtained the eighth day of hospitalization was negative, as was each succeeding culture. It is also significant that with both our case and the case reported by Dr. Griffey² both retained 20/20 vision in the affected eye at the close of treatment.

Penicillin does present a promising future in the management of gonorrheal ophthalmia. Until much more experience is gained, we must of necessity accept the results of this case, and the few others reported, with caution.

SURGERY OF TRAUMA AND ITS IMPORTANCE AS AN EMERGENCY*

LEO K. COOPER, M.D.

GARY

This paper is in no way meant to be profound, nor is it a compendium of injury and treatment. I have gone through much of the grief of a general practitioner. I have gone through a lot of grief since my training in orthopedic surgery started eight years ago. In my own way, I hope I can present a few of the problems which confront the average man, and perhaps be of some slight service. I have also been familiar with the problems that confront the average man who comes to a post-graduate center for some special training, and it is along these lines that I have developed my paper.

In this day of world-wide war, with casualties and injuries that stagger the imagination, one reads the marvelous statistics of the present World War as compared to the number of deaths and the amount of disability resulting from similar injuries in World War I. It is here that a great deal of our interest stops, but let us remember that this improvement has been due to emergency treatment in any of its phases.

We must consider the injuries that occur in civilian life, the cases that come to us as private patients. We must at once determine what is best for the patient. It is at this moment that a vast number of questions start running through one's mind. Generally the first question is, "Can it wait until morning, or should it be done now?" Here I am going to pose a pertinent question. On September 25, 1944, I received a letter from a Colorado physician, asking me what traumatic conditions I considered to be of an emergency nature, and which of these could safely be handled by the general practitioner living eighty to one hundred miles away from a surgical center. I will attempt to answer this question quickly by stating that under any conditions where one exhausts every effort, mental and physical, to do the right thing, they can be safely handled under the circumstances.

No one can expect the impossible. However, unless one does everything possible, a certain amount of remorse must certainly be felt.

In every phase of surgery we must consider pathology. Let us think along the lines of pathology for a moment. Pathology must be encompassed by surgical judgment. From long experience we know that any tissue at the moment of its injury is better able to handle infection than at any other time. Following the occurrence of a wound, if initial first-aid and treatment can be carried out immediately, the patient has a better chance to escape infection than he would have if some sort of surgical treatment were going to be attempted about twelve hours or more after the occurrence of the wound. It is from this time on—namely, twelve hours—that any injured tissue undergoes the primary stages of infection or tissue repair, characterized by edema, lowered resistance, et cetera, but still at the same time it is able to stave off disaster.

If this area of tissue be further traumatized by delayed surgery, it is common knowledge that ensuing infection frequently occurs, and for this reason it is injudicious to attempt the suture of nerves, tendons, or muscles which have been torn or lacerated as the result of a compound wound. The reason for emergency surgery is thus self-explanatory.

Trauma:

Trauma is defined as a wound or injury. In this paper this does not apply to actual trauma of dentistry or to psychic trauma, in which an emotional shock makes a lasting impression on the mind.

Trauma can be caused by mechanical, chemical, or physical means, and for the purpose of further limiting this paper to trauma caused by mechanical means, we shall deal with injuries associated as a result of mechanical causes. Trauma can occur or be caused by any object being hurled against the

* Presented before the Surgical Section of the Indiana State Medical Association, at Indianapolis, October 4, 1944.

body, or having the body hurled against an object. In either event the resulting trauma can be of a simple nature or a very complex condition, even to death. For this reason a number of the more frequent conditions occurring in civil life will be dealt with because of their apparent simplicity and dreadful sequelae, or because of their apparent seriousness and expected ensuing disability.

Etiology:

The etiological agent may be large or small, sharp or dull, of low or high velocity, clean or soiled, or there may be embedded a foreign body, such as clothing, gun-wadding, dirt, steel, et cetera, which has been carried in to the tissue by the activating forces. Severe crushing of the body or any extremity may occur when caught between two objects.

Pathology:

The result of the trauma, generally speaking, is the same in any part of the body so far as injury to the tissue is concerned. The specific result of the area is dependent upon the part of the body injured, as well as the size and force of the acting agent.

The extent of the injury must be considered. Is it simple or compound? If it is simple, what are the underlying structures liable or subject to injury? Is the individual practically asymptomatic following the injury? If the injury is compound one must consider the extent of the wound, whether it was made with a sharp or dull instrument, or weapon, and if while going through the tissues it made a clean or jagged wound.

Jagged extensive wounds with traumatized and necrotic tissue make a good media for subsequent infection. At such a time one must consider whether or not the wound is clean and will heal by first intention, or whether a secondary infection is likely to occur. If so, what are the types of infection most likely to occur? What are the clinical symptoms at the moment, and what can be done to prevent infection?

Bacteriology:

Following treatment of the initial injury, the wound may recover with or without infection, but if infection should occur, the most common type of infecting organisms are the staphylococccic group, the streptococccic group, and the anaerobes or gas bacillus, such as *B. Welchii*, or vibriion septique.

Anatomy:

In any injury the part of the body affected must be considered along with the underlying structures which may be present. In injuries of the head, the brain and the meninges and the nerve centers, et cetera, must be kept in mind as well as the possibility of a blood-vessel injury and extra-dural hemorrhage.

In other areas one must keep in mind the presence of spinal nerve cells, as well as peripheral nerves. One must also remember the presence of

tendons, muscles, blood vessels, as injuries, slight or severe, might involve a single muscle or a group of muscles, or an entire extremity.

Symptoms:

(1) Symptoms of skull injuries may be simply a scalp laceration with a palpable depression, with or without symptoms. There may be hemorrhage from the nose with ecchymosis of the orbits, in the event of a fracture of the anterior fossa, and hemorrhage into the ears in fractures of the middle fossa. In the event of a fracture of the posterior fossa, or basilar fracture, there is usually a loss of consciousness, stertorous breathing, and a very bloody spinal fluid.

(2) Other symptoms may be immediate or delayed, as occurs in middle meningeal hemorrhage.

Spine:

In injuries of the spine, including the cervical and sacral region, one may suffer from a mild fracture to a fracture dislocation, with symptoms ranging from mild to complete paralysis, and death. Here again one should remember the importance of spinal fluid findings, such as pressure, blood, et cetera.

Chest:

Chest injuries may result in hemorrhage, shock, emphysema, pneumothorax, bloody, frothy sputum, or death, depending on the passage of the object or structures encompassed by the trauma. Here, one must think of vagus nerves, phrenic nerves, vital organs and structures immediately below the diaphragm.

In the abdomen, again, an injury of any magnitude must be suspected, depending upon the symptoms, type, and location of the injury.

Extremities:

The extremities, which seem to be the part of the body most frequently injured, contain all the elements which should be watched for, except those found in the central nervous system. Because of their terminal position and blood supply, it is important to note any loss of function or deformity such as occurs in fractures, and the condition of the circulation.

In the case of a simple fracture without extensive soft tissue damage, there is little to worry about. In lacerating injuries, or where trauma has been severe or associated with terrific forces and extensive soft tissue damage, one must keep in mind the presence of specific nerves in the involved area—or it may be tendons, bones, muscles, or blood vessels. If any motions to a specific part are not present, the wound should be investigated with the thought of nerve or tendon injuries.

In very simple injuries, particularly in children, a common occurrence is a fracture through an epiphyseal line, or a dislocation of the epiphysis from the shaft of the bone. These fractures or injuries, though apparently very simple, may have a long-range result, characterized by epiphyseal arrest, in which the growing portion of the bone

becomes fused and fails to develop as it would under ordinary circumstances. In this event, a future deformity of the injured joint may be expected because of a disproportion of the growth, or rather the continuation of growth on one side of the joint while it has practically ceased on the other side.

For this reason it is very important that the parents of juvenile patients should always be warned of this danger at this time, and a record of the possibility should be made and put on the hospital chart.

Treatment:

The treatment of any trauma should be administered immediately. Procrastination is not only wrong but is harmful to the patient. If one is unable to treat an injury at any hour of the day or night, then it should be treated by someone else immediately, where possible.

The conditions most frequently associated with traumatic injuries are:

(1) Hemorrhage, which might necessitate suture, ligature, fluids, plasma or blood transfusion.

(2) Shock, which might require warmth, morphine, and stimulants.

(3) Thorough debridement, of a wound (under tourniquet if possible, or necessary), as there is nothing else in surgery that takes the place of good surgery. Prolonged irrigation of dirty soiled wounds is imperative. Every portion of dirt, devitalized tissue, and foreign bodies should be removed within the limits of surgical harm or shock.

(4) Immediate repair of any lacerated or cut nerves, tendons, or muscles.

(5) Immediate reduction and immobilization of fractures by manual manipulation and plaster casts or molds, by skin traction, or by skeletal traction if there happens to be any contraindications, such as lacerations and contusions, which would prevent skin traction.

It has been the common teaching in the event of severe injuries and fractures that the shock should be treated, and then the patient should remain under shock treatment until further work can be done. In my experience, where fracture of the extremity is the main cause of disability—and I would say that this still further applies to fractures of the femur—shock is best treated by the immediate application of traction, be it either skin traction or skeletal traction.

I have seen many instances where a patient with a fractured femur, lying on a simple hospital cart, was relieved from his shock symptoms in a matter of five to ten minutes by the simple application of skin traction with twenty to thirty pounds weight temporarily, and I believe that this is a very important point, and should be kept in mind. Any concomitant treatment for shock is fine, but always keep in mind the necessity for traction where possible.

In the event that a satisfactory reduction of a

fractured bone cannot be obtained without too much trauma, as a result of skin traction, skeletal traction, or manual manipulation, and within a reasonable amount of time, up to ten or twelve days, an open reduction is indicated.

Dislocations:

Dislocation of any of the body joints should be cared for at the earliest possible time, followed by immobilization and necessary x-rays. Here again the physician should keep in mind the frequent occurrence of myositis ossificans, and guard himself with a word of warning to the patient or relatives. It might also be well to think of future hip-joint diseases if the head of the femur has been dislocated. At this point it might also be wise to mention that fresh fractures and injuries are more safely immobilized by means of plaster splints, rather than by plaster casts, in order to guard against swelling or disturbance of circulation of a part.

(6) Elevation of an extremity which may have an embarrassed circulation.

(7) Exploration of an extremity which has an ascending swelling due to hemorrhage, with a cold, pulseless portion distal to the swelling or hemorrhage.

(8) Only after a thorough debridement, an examination of the wound and devitalized tissues, for injury to important structures, should chemotherapy be brought into play in the form of local medication.

This should consist of the use of sulfa drugs, locally, (I use sulfathiazole crystals only when I feel that the wound might not be clean), and by mouth.

In grave cases a quarter million units of penicillin should be started immediately.

A combination of tetanus and gas gangrene antitoxin should be given routinely, following a therapeutic test for sensitivity.

(9) X-Rays:

X-rays are an essential part in the treatment in traumatic wounds or traumatic injuries as a whole. However, it is necessary that surgical judgment be used when x-rays are indicated. If the patient is seriously injured, or in shock, this phase of the treatment should be delayed until such time as the patient can be safely moved.

Following the initial first-aid and treatment, the clinical course will govern the subsequent treatment. If infection does supervene, it will be characterized by typical signs, such as temperature, malaise, pain, swelling, redness, et cetera, and necessary steps must be taken to combat the infection, as follows:

1. Establish drainage.
2. Determine the type of organism.
3. Incision and excision of tissue, as indicated, for example, in gas bacillus infections.
4. Chemotherapy.
5. Removal of sequestra in the later stages of infection.

ALCOHOLICS ANONYMOUS*

For the Treatment of Chronic Alcoholism

GRANT E. METCALFE, M.D.

SOUTH BEND

Current literature referring to the treatment of chronic alcoholism notes that the usual therapy, including amphetamine, vitamins, sedation, hospitalization, and psychotherapy, is woefully inadequate. All authors agree as to the seriousness of the problem of chronic alcoholism to the alcoholic, his friends, relatives, the clergy, social organizations, and the medical profession.

The majority of treated hospital patients become good patients, are relatively agreeable and co-operative during treatment, and leave the hospital with the best of intentions and promises, only to return in their previous condition, or worse. Again they are built up physically, "dried out," reassured, given psychotherapy, and then sent out again. The procedure is usually repeated many times with similar results. A few seem to profit from their experiences and treatment. An excellent review of the varied etiological concepts and treatment of such cases is referred to by Thompson.¹ These investigations have undoubtedly contributed much to our knowledge of alcoholism, but their very number of conclusions indicates that the problem is still quite difficult. Alcoholism continues to increase and become a great social menace. With tuberculosis, cancer, syphilis, mental disease, and infantile paralysis receiving competent and intelligent medical attention, alcoholism was the greatest public health problem not being systematically attacked prior to the formation of the Research Council on Problems of Alcohol.² Such scientific investigation of the causes and problems of alcohol should be earnestly supported; they are most certain to render a great service to humanity in the future. But what of the present? Of the problems of alcohol that are before us today?

Much work has been done by religious organizations and temperance societies. All of us have seen their methods of approach. These include dramas presenting the terrifying results of alcoholism, pamphlets, the signing of pledges, et cetera, all similar in their emotional appeal.

The value of approaching problems in groups has long been recognized and has assisted many alcoholics. The Peabody Group and the Oxford Movement and others have convinced us of their value.

"Alcoholics Anonymous" is a group approach to the problem of alcoholism, which has been the outgrowth of one of man's attempts to help himself through religion. Momentum has been gained by this method through its success where others have failed. Even though you have little belief in the efficacy of "cures" which do not appear to be scientific, do not lightly dismiss their approach to the alcoholic problem. An increasing number of references to the assistance of this movement in dealing with alcoholism are to be found in medical literature. Heersema,³ Smith,⁴ Thompson,¹ Silkworth,⁵ Seliger,⁶ Miller,³ Bowman,⁷ Tiebout⁸ and others recognize its value. The patients in most of the New York City metropolitan area hospitals who suffer from alcoholism are encouraged to utilize "Alcoholics Anonymous," Smith⁵ and Thompson² report of their experiences at the Rockland State Hospital. At the Chicago and Manteno State Hospitals in Illinois special alcoholic services have been set up⁹ "to be used for patients of the type in whom the prospect of rehabilitation is especially good, the majority of beds to be available for patients who give prospect of benefiting from the Alcoholics Anonymous Technic." Patients who are mentally ill are handled separately in these two hospitals. These are only three of many established public hospitals cooperating with the Alcoholics Anonymous Movement.

The announced plan to establish a diagnostic clinic for inebriates in New Haven, Connecticut, in February, 1944, and later in Hartford, Connecticut, under the sponsorship of the Yale Laboratory of Applied Physiology and the Connecticut Prison Association with the active participation of the Connecticut Medical Society and religious and civic

³ Miller, Michael M.: Ambulatory Treatment of Chronic Alcoholism, *J.A.M.A.*, **120**:271, (September 26) 1942.

⁴ Smith, Percy L.: Alcoholics Anonymous, *Psychiat. Quart.*, **15**:554, (July) 1941.

⁵ Silkworth, William D.: A Highly Successful Approach to the Alcoholic Problem, *Med. Record*, **154**:105, (August 6) 1941.

⁶ Seliger, Robert V.: Discussion of Paper by Lemere, Frederick; Voegtlin, Walter L.; Broz, William R.; O'Hallaren, Paul; and Tupper, Warren: The Conditioned Reflex Treatment of Chronic Alcoholism, *J.A.M.A.*, **120**:269, (September 26) 1942.

⁷ Bowman, Karl: Review of Psychiatric Progress in 1942—Alcoholism, Neurosyphilis and Geriatrics, *Am. J. Psychiat.*, **99**:598, (January) 1943.

⁸ Tiebout, Harry M.: Therapeutic Mechanisms of Alcoholics Anonymous, *Am. J. Psychiat.*, **100**:468, (January) 1944.

⁹ Medical News, *J.A.M.A.*, **122**:243, (May 22) 1943.

* Presented at a meeting of the St. Joseph County Medical Society, held January 25, 1944, at South Bend, Indiana.

¹ Thompson, Walter A.: The Treatment of Chronic Alcoholism, *Am. J. Psychiat.*, **98**:846, (May) 1942.

² Moore, Merrill: Alcoholism: Some Contemporary Opinions, *Am. J. Psychiat.*, **97**:1455, (May) 1941.

organizations, includes the use of Alcoholics Anonymous.

Silkworth⁵ quotes Saul and Hammer of Philadelphia's St. Luke and Children's Hospital, Turnbull and Stouffer of the Philadelphia General Hospital, Blaisdell of the Rockland (New York) State Hospital, and the Charles B. Towne Hospital of New York City in elaborating on his statement, "The physician while an earnest seeker after truth is in no position to recommend all the fads presented to him. Here is a plan emanating from no 'authority'—there are no leaders, there is nothing to sell, it is strictly ethical, and it asks for and receives the co-operation of physicians."

The group frequently requests, from the medical profession, assistance in the detoxification of the new members preparatory to the establishment of their program. The executive board of Alcoholics Anonymous desires to establish local medical consultation facilities for the determination of causes of failure. Often the alcoholism is symptomatic of an underlying organic condition or psychosis.

The Alcoholics Anonymous Movement is not a prohibitionist, reforming, or temperance organization. There is no desire to interfere with the alcoholic habits of those who can control their drinking. In the spring of 1939 more than one hundred recovering alcoholics published a book entitled "Alcoholics Anonymous,"¹⁰ explaining their principles and telling of their experiences and recoveries. The purpose of the organization is to show other alcoholics how they have recovered. They recognize that they "can never use alcohol safely in any form . . . it is not a problem of mental control alone." They feel that an alcoholic can make a better approach to another alcoholic than a non-alcoholic. Failures are said to be rare in those who thoroughly follow the Alcoholics Anonymous path. These failures are the persons who cannot or will not give themselves completely to the simple program. They are constitutionally incapable of being honest with themselves. Thompson¹ and Smith⁴ both point out that they must *want* to overcome their alcoholism.

The usual approach is as follows: Alcoholics Anonymous members relate their own stories—what they were like; what happened; and what they are like at present. The alcoholic must then decide he is truly an alcoholic, that he wishes to do something about the situation, that he desires of what Alcoholics Anonymous has to offer, and that he is determined to make a great effort to follow their program. He is then ready to take the steps in the Alcoholics Anonymous program of rehabilitation and recovery. They are as follows:

1. We admitted we were powerless over alcohol—that our lives had been unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God, "as we understood Him."

4. Made a searching and fearful moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory, and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, "as we understood Him," praying only for knowledge of His will for us, and the power to carry it out.

12. Having had a spiritual experience as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

These twelve steps are discussed from time to time. The book is read and studied by new members. As soon as the alcoholic understands himself—and not until then—he is expected to approach other alcoholics, seeking and helping others and himself.

Alcoholics Anonymous meet several times a week, inviting husbands, wives, and friends. The recreational and socializing contacts are an important part of the program. The cohesive factor is the mutual objective of the members in defeating the habit of alcoholism. The movement is now quite extensive, and a local group is to be found in most fair-sized cities. Such a group exists in South Bend.

RESULTS

Thompson¹ and Smith⁴ report 56.9 and 50.5 per cent as making an adjustment with the help of Alcoholics Anonymous. The only reliable reports in the entire medical literature for comparison are those of:

1. Fleming and Tillotson¹¹ showing only 15 per cent of 124 patients still abstinent at the end of eighteen months.

2. Lemere and his associates, using the conditioned reflex treatment, reports that in 1,194 patients "followed up," 74.8 per cent treated within the preceding two years were still abstinent, that 52.5 per cent of 291 patients treated from two to four years previously were still abstinent, and that 51.5 per cent of 259 patients treated four or more years previously were still abstinent.

¹¹ Fleming, R., and Tillotson, K. J.: Further Studies of the Personality and Sociological Factors in the Prognosis and Treatment of Chronic Alcoholism, *New England J. Med.*, 221:741, (November 9) 1939.

¹⁰ *Alcoholics Anonymous*, Work Publishing Co., New York, 1939.

3. Miller³ reports that of 487 patients contacted, 391, or 81.2 per cent, were abstinent.

Smith and Thompson's group were state hospital patients, whereas those of Lemere and his associates were mostly voluntary, responsible individuals. They state that no psychotherapy was attempted, but recognized the need for a rehabilitation program in conjunction with their treatment. In addition, they note that "in districts where field representatives (usually ex-patients with special training) kept in close touch with the patient and assisted him in getting straightened out with his family and his job, the results were substantially better than in those areas where this was not done." Miller's patients were under sentence in the workhouse by agreement with the court, and were all re-arrested alcoholics. In addition to the use of amphetamine and phenobarbital, he used psychotherapy and "patients were urged also to enter the Alcoholics Anonymous . . . and encouraged to assist in the rehabilitation of others."

The author's six cases have been seen for too short a time since their participation in this program, but at least two who have been on the program for eight and twelve months present striking changes in personality. This has been noted by others.^{1, 2, 4, 5}

COMMENTS

Your author is interested in knowing why this particular approach appears to be so successful. It has long been recognized that religious fervor, sometimes amounting to fanaticism, produces abstinence in alcoholics. They seem to lean on religion instead of the bottle. The religious factors in Alcoholics Anonymous do to a certain extent limit its use, but while religion is not a prominent part of the movement, it is important, and some alcoholics find it hard to accept even before knowing what it is all about. Their conception of the "greater power" is liberal and ordinarily not put into words for the specific reason that all religious faiths can be embraced and because many alcoholics would abhor direct thought or expression of God. The alcoholic is told not to put his faith in God, or the Vir-

gin Mary, but merely to conceive that there is someone stronger than himself if he will help himself. It is your author's belief that religion is inherent to man because some type of religion is seen in all levels of civilization. True, the primitive may have a dozen gods, but it is his way of denoting the presence of some power that has some control of his destinies. This type of reference to God or gods appearing to be inherent to man and not being involved in theological differences is not too difficult to accept.

Probably that which is at least as important, if not more so, than the religious angle are the opportunities for group psychotherapy (now being used extensively in the armed forces and to a degree elsewhere), a part of which is the important socializing portion of the program and the helping of others. There is a tremendous opportunity for the utilization of one's energy drives in physical, emotional, and intellectual fields. The damming up of this energy within one's self probably is one of the factors noted in the pre-drinking period, when "he is restless, irritable, and discontented unless he can again experience the sense of ease and comfort which comes at once by taking a few drinks—drinks which he sees others taking with impunity."¹⁰ No successful treatment of alcoholism can ignore the great value and necessity of engaging actively in social activities and constructive ways of employing vocational ability and leisure time. Your author can see how it can be attained outside an abstinent group, but in common with others he has had little success when attempting this with the alcoholic. The alcoholic's friends have all been alcoholics, and much of his recreational and socializing—and in some instances vocational—contacts have been dependent upon the assistance of alcohol, and without the assistance of others with whom he has a common bond of some type his opportunities to alter personality factors involved are not great. No matter how good his intentions are to be abstinent, the old personality needs must be met.

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ABSTRACT

WAR-TIME CONDITIONS FORCE CHANGE OF MEETING PLACE FOR 1945 SESSION

Because of conditions brought about by the war the necessary facilities will not be available in New York City for the 1945 annual session of the American Medical Association, scheduled for June 11 to 15, and thus it will have to be held in some other city where adequate facilities will be available, it is reported in the November 11 issue of *The Journal* of the Association. The announcement says:

"The House of Delegates of the American Medical Association at the annual session held in 1942 selected New York City as the place of meeting for the 1945 annual session. Certain preliminary arrangements were

completed, but investigations recently made in New York clearly indicate that the necessary facilities will not be available in that city in 1945 because of conditions created by the war emergency. It is with regret that it is necessary to make the announcement that the annual session scheduled for New York, June 11 to 15, 1945, will have to be held in some other city where adequate facilities will be available. Under the direction of the Board of Trustees necessary investigations are now in progress and definite announcement as to the place of meeting for 1945 will be made through the columns of *The Journal* at the earliest possible time."

THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL
PROFESSION OF INDIANA
Copyright, 1944, Indiana State Medical Association

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DECEMBER, 1944

Editorials

Christmas Greetings

The Yuletide of 1944 again is overshadowed by the World War. Homes that in former years were the scene of gaiety, the gathering of all members of the family, and the big Christmas dinner—a part of our national life—will feel the somber effect of war.

Yet with all this, Christmas means much to all of us; it is the celebration of the natal day of the Prince of Peace, and we trust that each of our members may find a happy thought in this.

THE JOURNAL hopes that even though this may perhaps not be a Merry Christmas in many homes, that it may be one of contemplation of the day when the war shall have ended and our loved ones shall again be with us, and the Prince of Peace shall again rule the world.

THE SPECIAL SESSION

The House of Delegates of the Indiana State Medical Association met in special session, at Indianapolis, on November twelfth, with President Oliphant presiding. The attendance exceeded most expectations, there being 102 voting delegates present, also five officers and one visitor, Dr. A. S.

Brunk, president of the Michigan State Medical Society. The meeting had been called for a further consideration of some health insurance plans, a report on which was made by a special reference committee at the recent annual meeting.

President Oliphant announced what he called the “ground rules” for the session, outlining its purpose and the plan of attack upon the problem before the House; at once the meeting got under way and for more than four hours the delegates wrestled with the many phases of the problem.

F. S. Crockett, chairman of the special reference committee, presented the report of the committee as read at the last regular session.

It was at once apparent that many of the delegates were not voting their personal convictions in every instance; rather were they voting according to instructions from their local society; thus, it was made clear that during the past few weeks the matter had had serious consideration on the “home front.”

Doctor Brunk gave a report on what his home state, Michigan, had done concerning the problem, giving a brief resumé of the “Michigan Plan.” Then a vote was taken as to whether Indiana should attempt to organize some sort of plan for health insurance. From the vote, 66 to 33, it was apparent that such a plan was deemed desirable by a large majority of our local medical groups.

Chairman Crockett then moved that the Indiana State Medical Association approve a mutual, non-profit indemnity insurance plan, which motion was adopted by a vote of 52½ to 45½, the one-half vote being due to the dilemma in which Councilor Wadsworth, of the Second District, found himself, his county society groups being equally divided on the question.

Minor amendments to this motion had been made before the vote was taken.

Later in the meeting it was moved and carried that this question be reconsidered, and the vote was greatly in favor of such reconsideration. When the question was again put before the House, the vote was 80 to 16 against the “non-profit, mutual” proposition, thus opening the way for the motion that was then made by Dr. M. C. Topping, of Vigo County, asking that the words “non-profit, mutual” be eliminated, and thus leaving the selection of a plan open to other indemnity plans as well as a non-profit, mutual insurance plan.

A motion was then passed to the effect that the whole problem was to be referred to a committee for further study, this committee to bring in a definite plan for action, and that when and if this was done, another special session of the House would be called.

Thus it might appear off-hand that little was accomplished at this meeting, but, as a matter of fact, much was accomplished, for the delegates came away with a better understanding of the entire problem, and generally it is believed that when they are called together again some definite action will be taken.

THE IMMUNIZATION PROGRAM

One might think that with all the publicity given the subject, plus the activity of many of our county medical societies, that immunization in Indiana had about reached the top. However, it is evident from reports that filter in that this is not true. In some of our counties the immunization program has been carried out on a rather exact scale, that is, a definite program was laid out and followed to the very letter. In these areas, of course, the controllable diseases are rather uncommon as a result of this work.

The recent report as to the prevalence of smallpox in Indiana seems to have aroused the interest of health officers in some of our larger cities, Terre Haute being one. According to press reports, the City Board of Health in that community has sent a letter to the parents of every non-immunized child in the city. This letter points out that Indiana had more smallpox this past year than any other northern state, and that the city of Terre Haute, and Vigo County, led all others in the matter of diphtheria cases.

The board strongly urges all parents to have their children immunized, not only against smallpox but many other of the communicable diseases as well. They also point out that in families where the expense of this treatment would be a hardship, arrangements can be made whereby such immunization will be done at public expense. The local health records show that less than fifty per cent of the children of the city have been properly immunized. It probably is true that in many instances a child has been immunized, but that the attending physician has failed to make a report thereof; such instances will, of course, be cleared up when the parents receive the notice from the board.

The Terre Haute papers, both the *Star* and *Spectator*, are lending full support to the project. The *Star* carries a very well-written editorial, with

an unusual heading, "Murder Without Penalty." The writer opens his comment with the statement, "Society has not yet been brought around to realize the fact, but it stands, nevertheless, that murder charges would be appropriate in the death of any child who has not been immunized against the disease causing his death, when that immunization is available. It might have been true at one time that financial position or distance from medical attention could have prevented giving some children proper attention against communicable disease, but it is not true today."

MOTIONS PASSED BY HOUSE OF DELEGATES, INDIANA STATE MEDICAL ASSOCIATION, IN SPECIAL SESSION NOVEMBER 12, 1944

- (1) Your Committee recommends and moves that the State Medical Association approve a prepayment plan of health insurance.
- (2) Your Committee recommends and moves that the State Medical Association approve an indemnity type of prepayment health insurance.
- (3) Your Committee recommends that the President, with the advice and approval of the Council, appoint a committee which is representative of the physicians, both as to geographical distribution and as to kinds of practice, to work out a plan to carry into effect the provisions of the motions already adopted relating to this report, which plans and provisions shall not be placed in operation until said completed plans and provisions and contracts are submitted to this House of Delegates for final approval or rejection.
- (4) Your Committee recommends that the President of this Association call a special session of the House of Delegates to consider this problem when it is ready for presentation by this committee.

(Minutes of Special Meeting on page 726)

The editorial states that Vigo County is down in the list, so far as immunization goes, and that something must be done about it.

It probably is quite true that other areas in the Hoosier State are in the same predicament; we know about some of them, but there probably are others in which the right sort of survey has not been made, hence the true situation is not known.

As this editorial points out, there is no reason for most deaths from communicable diseases; each such death is an indictment on

some person or persons. Of course, the first blame is always laid at the door of the medical profession, no matter how many preachments organized medicine has made on the subject. Just why all the health problems should be laid at the door of our profession is quite beyond us. We have health offices and health officers in every community; some are doing a good service; some, frankly, are not.

It all boils down to one thing: the sooner we have a complete reorganization of *all* health departments, from the Indiana State Board of Health on down, just that much sooner will we exercise the proper degree of control on communicable diseases.

Many physicians in private practice are doing a good, personally-conducted, health-officer job; they daily and consistently preach health measures; they urge immunization, and keep on urging until it is accomplished. Others, with a will to do what they can, make pleas for such immunizations, then, in

the stress of other duties, do not follow it up. *If we had full-time health officers in every section of the state, the problem would be settled in jig time.*

As it now stands, we are doing the best we can with the facilities at our command; we are giving the matter all the publicity possible; we have the full support of the Indiana press, hence, we feel that we cannot be blamed for these deaths. Yet, there is a certain per cent of the public which demands that the medical profession do something about it — they even go so far as to say that State Medicine is the answer.

We hope that we may see the time when Utopia is among us, when we have active, energetic, competent health officers, of the full-time variety, in every section of Indiana.

REFRACTIONS IN CHILDREN

Of recent years much progress has been made in the matter of care of the eyes of children; not too long ago the idea that "they will outgrow this trouble" was current even among some medical men, who so advised parents regarding their offspring. Even in cases of squint, commonly known as "crossed eyes," was such advice handed out. Fortunately, such suggestions are now seldom made and children with such a defect are at once referred for proper examination.

But even so, too many of these cases do not reach the oculist, or eye physician, immediately; too often they are sent to the optometrists. While we have no personal quarrel with members of that profession, we do feel that such cases call for a refraction by an eye physician, under cycloplegia, preferably atropine.

Only recently we had several such cases, all of whom were wearing glasses prescribed without the use of atropine, and in each instance the examiner "missed the boat" by a big margin.

Here are three of this group of cases, illustrative of improper corrections and consequent discomfort to the patients:

Case 1. Aged eight. This child had been to an optometrist, who prescribed glasses. The child complained of inability to "see good," and a change in correction was made, but without much improvement. At the time she first came in she was wearing, both eyes, a plus 1.00 spherical lens. Under atropine the refraction showed that she required a minus compound, with which she has normal vision, is quite comfortable with her glasses, and does far better school work, so her teacher reports.

Case 2. This girl was wearing a plus 1.00 spherical correction, and for close work had been given an additional correction, in the form of bifocal lenses. This, even though she was a youngster! Atropine refraction showed a rather high degree

of simple myopia, and proper correction gave immediate relief and normal vision, single vision lenses, of course, being prescribed.

Case 3. This girl was wearing a correction for myopia, but she, too, had been given bifocals with which she was experiencing trouble, no end. Atropine refraction showed a compound myopia, and the proper correction, single vision lenses, gave normal vision, and the little patient experienced no further visual difficulties.

These cases are but a few of the many that come to our attention, and, not uncommonly, some of them had been refracted by physicians, not specialists but those engaged in general practice. One such youngster about nine years of age had been checked by the family doctor, who pronounced her eyes normal simply because she was able to read the 20/20 Snellen line. However, she was far behind in her school work, and the principal of her school had adjudged her a fit candidate for the "sub-normal" room.

A refraction under atropine developed the fact that she had a very high degree of hyperopia, and proper correcting lenses not only saved her from the sub-normal classification but enabled her to pick up her classes in a period of less than two years.

The greatest offenders of all, in our experience, are the chain store refractionists. They are the ones who do the blatant advertising, and are especially prone to advise parents to bring their young children to their offices. As a rule these "optical parlors" are very poorly manned, the refractionists, of course, having no personal interest in the little patients, and it is but natural that the examination given is of the superficial variety. We see scores of such cases.

Physicians are advised to be guarded in giving an opinion regarding the eyes of these little folk; as a matter of fact, many physicians of our acquaintance recommend a thorough eye examination of all children of pre-school age, which we deem very wholesome advice.

ONE OF THE TRENDS OF THE TIMES

Much is being written about the effect of the World War on modern youth, specifically referring to the 'teen age. We shall not essay a discussion of this problem from the standpoint of moral delinquency, confining ourselves to comment on but one phase of the problem. Most of us are familiar with the trend of the times in this connection, among the children of the neighborhood. Formerly went to play the games of our childhood, Duck-on-the-Rock, Three-Corner Cat, et cetera, our youngsters now engage in wartime exhibitions.

Most any day we note a procession of "soldiers" passing our home, each carrying some sort of

gadget representing arms. At other times there is organized "war," with the Allies on one side and the poor Japs on the other—you do not hear much about a war against the Germans.

Later on, through one means or another, some of the group come into possession of air guns, those instruments of the devil himself—such is our personal characterization of the alleged toys. We have seen a few instances in which these air guns have been used in "combat," wondering the while why there are not more injuries resulting therefrom.

These same air gun addicts, when not engaged in playing war, go about the alleys promiscuously shooting at "marks," or some poor bird that happens into view, not caring about the windows in the neighborhood or the residents thereof.

Then there are other weapons equally dangerous and equally destructive. Only the other day we were walking along one of our parks and noted three boys shooting at birds with home-made slingshots. As a matter of fact, we chased these boys for several blocks, wishing to talk to them about the evils of such practices.

That we are not alone in our condemnation of these things is evidenced by an editorial in the rather staid *New England Journal of Medicine*, "Injuries to the Eyes" from Air Rifles," an article prompted by a letter received from the Director of the Massachusetts State Division of the Blind. It seems that in that state there is a law making it compulsory to report all injuries received from air rifles, which would seem to be evidence that such injuries are all too common.

The editorial in question recites the fact that while such injuries do not commonly result in a perforation of the globe, the damage sustained is all too often of a serious nature. Such a blow upon the eye may result in a number of serious, permanent injuries to some of the intra-ocular structures.

We are an ardent advocate of play for our youngsters, but we do believe that some of their activities might well be curbed. Some day, someone is going to compile a list of serious injuries produced by air guns and slingshots, and when that time comes our eyes will be opened—wide, and then we may do something about it.

JOURNAL COVER PAGE

To most of our members in the armed forces this will not be a "White Christmas," but will more nearly approximate the picture used on our cover page, which is an official photo by the United States Air Forces, showing a Squadron Air Station . . . first call for sick and wounded in combat zone. This AAF medical unit is in training under simulated combat conditions. It is our fervent hope that our next Christmas may be celebrated in the traditional American way.

Editorial Notes

The average length of life of Americans, in the year 1942, was found to be 64.82 years, the highest on record to that date. At the beginning of the century the average age was 49.6, thus we have added to our life expectancy, in a matter of forty-two years, fifteen and one-half years. If this ratio should continue, we will in time have a lot of hundred-year-olds roaming the state.

The health officers of Indiana are moving along in perfecting their organization. The committee on constitution and by-laws have held its meeting and is about ready to submit the results of its labors to a meeting of the association, to be held early in December of this year. It is to be hoped that the health officers will be able to perfect a strong organization, one which will lead in matters of public health in Indiana. It has great possibilities for good influence on behalf of both the public and the medical profession alike.

Several bills have been introduced into Congress, providing for the establishment of quotas for pre-medical and pre-dental students, each year. This is a very important matter, and we trust that Congress will give prompt attention to the subject. We need some provision whereby at least six thousand medical students will enter our medical schools each year, this group not to be composed of rejectees in the Selective Service but of young men and women who are chosen in the pre-war manner—sort of "hand picked," if you please. Our medical schools must go on and on, and their students must continue to be the "cream" of the annual crop of college graduates.

The Journal of the American Medical Association, of October twenty-eighth, published a letter from its correspondent in Belgium, this being the first medical report to be received from a Nazi-liberated nation. In that letter the writer makes the following comment on World War II treatment of casualties: "We, the Belgian physicians, wish to express also our deep gratitude to your country and our admiration for your Army. We are now able to see for ourselves, on our re-conquered soil, the amazing organization of war surgery that has been built up by the Allies at the front. Because of our experience with the hospitals during the war of 1914-1918, we can appreciate the progress achieved in the care of the wounded, and we propose to learn from contact with your medical officers the advances in war surgery that have given such good results in this war."

One of our medical officers located in South America, where he probably will remain for the duration, has decided to put in his sparetime in reading current medicine. He is a hopeful sort of chap, has the idea that he may be getting back to the States one of these days, and wants to brush up on modern medical advancement. He has submitted a list of the books he would like to have, books which if properly read would bring him right up to date. It might be a good idea for others, likewise situated, to adopt such a plan.

Paper towels, used by many physicians both at the office and at home, appear to be on the way "in" again; not that they have been completely off the market, but the supply at times has been limited. Now comes an official statement from the Treasury Department, Office of Surplus Property, stating that substantial quantities of filter paper will be sold to manufacturers of paper towels, et cetera. This Surplus Property Department seems to be getting busy these days, judging from press reports. As victory becomes nearer and nearer, the need for many articles will be materially lessened, which means the sale of this material to the public.

Most Indiana physicians have had a vacation of one kind or another, but there still remains a little while for such relaxations from the daily chore. The Indiana hunting season still affords an opportunity for a stroll in the open, and at least until early in January it will be permissible to get into the fields and look for the elusive rabbit. Even though one comes home with an empty bag, the tramp over the fields and through the woods will have been quite worth while. If you do bring home a rabbit or two, do not forget the precautions against tularemia infection, which still is quite prevalent in this state. Handling and dressing of rabbits call for protection of the hands, preferably using rubber gloves when handling them.

A letter from one of our Indiana physicians, now located in New Guinea, describes some of his activities. He states that war activities, in so far as battle casualties are concerned, are now at a minimum, the battle lines having moved into other areas, but that the treatment of the natives occupies much of the time of the Army doctor. Yaws is one of the commoner diseases with which this man meets, along with other tropical infections, "most of which I never heard much about," he says. We wager that soon after the war has ended there will be numerous books about these tropical diseases, all written by men who know what they are talking about, since they are right on the ground and are gaining an invaluable experience. And it is more than likely that there will be occasion to use this knowledge, right here in the United States, since many of these diseases will be transplanted here.

Motor vehicle fatalities were distinctly "on the up" for the first half of 1944, and from newspaper reports the ratio is continuing for the balance of the year. It was felt that with gas restrictions and a curbing of high speeds the death rate would be definitely lowered. This was true in 1943, but it seems that caution has been thrown to the four winds by many motorists, and that the hurry to get there is again rampant in our state. The few times we have been on the highways of late, we have seen far too many high speed chaps on the road, passing traffic on hills and not even slowing down for many of the curves. When the new cars get into circulation, and when gas is again available, we will have to do something about this, else the death rate will be appalling.

Many of the substances abounding in Nature, and with which our scientific friends have had a long-time acquaintance, are now being studied with a view of ascertaining what medicinal value, if any, they might possess. Take chlorophyll, for example; we first heard of this in our biology studies back in our high school days; most every youngster knows that this substance is the thing that makes grass, et cetera, green. Now it has been discovered that chlorophyll has a definite value in the treatment of certain wounds and burns, when used in the form of an ointment, which reminds us of a poultice prepared by an old aunt of ours, back in the Wild Cat days. She took the leaves of a plant locally known as "live-forever" and macerated them until they formed a jelly-like mass. This was then applied to the "stone bruises," so common among the barefoot youngsters of those days, and in no time the infection was cleared up.

Our November issue was late, plenty late, due to just one thing—delay in getting the material in—and after it had been set in type, delay in returning the corrected proof. Then, as usual, we had a few folk who wanted drastic changes made in their copy, necessitating the resetting of type. Even a few of our official family were extremely negligent in this regard. Because of the special session of the House of Delegates, it was deemed mighty important that this particular number be in the hands of the members on the first of the month; as it was, we had to pay a smart over-time price to have the presses run on Sunday, that we might get out enough copies to supply the delegates with theirs a few days before the session; the general membership did not receive theirs until several days later. One incident shows just what such delays mean: We had an editorial regarding the national election. Our personal copy of THE JOURNAL was laid on our desk *the morning after the election!* We again ask, as we have repeatedly asked, that prompt attention be given to material to be published, and that proofs be immediately read and returned to headquarters.

No longer should we use the term "patent medicines," says the Proprietary Association of America in a booklet prepared by its Executive Vice-President; rather should we term such compounds "proprietary medicines." This Association, by the way, has entered upon a public relations campaign. Were we to be asked for suggestions along this line, our reply would be that "Control of Blatant Medical Ads is Needed," and the subject of an editorial in *Editor and Publisher*, of December 18, 1943, might well be used as a foundation for such a campaign.

A commonly-asked question by youngsters with more or less serious visual errors is, "How long will I have to wear glasses?" Our customary reply is, "Oh, until you are about 108 years old." The other day a young miss, to whom we had made this reply on a previous visit, was in for a second refraction, and the same question was asked and the same reply given. She evidently was much impressed, and later on posed a question to her mother, "Do you know what I am going to do when I get to be 108? I am going to quit wearing glasses and start smoking cigarettes!"

The editor of the *New England Journal of Medicine*, for September 7, talks right out loud in his discussion of "Cold Vaccines." He discusses his personal experiences with this agent, and also reviews the controlled experiment of Drs. McGee, Andes, Plume and Hinton, of the Medical Department of the Hercules Powder Company. These physicians carried on this experiment on about one thousand employes of the company in the October-April season, and came to the final conclusion that cold vaccines did little good, with which opinion the editor of the *Journal* quoted seems to be quite in accord. The editor concludes his remarks with the naive statement, "Once again it has been shown that the administration of 'cold vaccines' merely means a waste of the physician's time and the patient's money."

Phi Delta Upsilon, medical fraternity, has established an annual series of lectureships at Indiana University School of Medicine, in memory of the late Dr. John Finch Barnhill, familiarly known to medical students of the past several decades as "Uncle Jeff." Doctor Barnhill was connected with the medical school over a long period of years, prior to which he was the head of the Department of Physiology in the old Central College of Physicians and Surgeons. His later assignment was as head of the Department of Otolaryngology; later he headed the Department of Head Surgery. A plaque will be hung in his honor in the medical school at Indiana University. On this plaque will be placed, each year, the name of the freshman medical student for that year who has done the most outstanding work in anatomy. One name already adorns this plaque, that of Maurice Turner, of Indianapolis, a freshman student of last year.

Somehow or other we overlooked a note of interest in *The Journal of the American Medical Association*, quite some time ago, relative to the innocuous use of corn silk as a tobacco substitute, a practice in which most of us indulged at some time in our youth. It seems that the Mayo Clinic had made a study of cigarette tobaccos, some of which they found to contain drugs that had an unwholesome effect on the vascular and nervous systems, and at the same time carried on an investigation of corn silk smoking. It was announced that the investigation showed no evil effects from smoking cigarettes made from corn silk, even the newspaper wrappers seeming not to cause any trouble. So Hoosier youth may continue this almost universal habit without untoward effect, provided, of course, they have access to a corn field.

From overseas reports it would seem that American Medicine is making a distinct "hit" with the natives of the South Sea Islands, due to the fact that these physicians are spending no little time in looking after the health of these folk. Many of the diseases incident to those areas long since had been deemed incurable, which might be expected to happen to a large percentage of the population. However, once the American physicians had looked over the situation, it was found that many of these ills were amenable to treatment. A large number of these people are being cured of long-standing illnesses, and naturally are very grateful to the American doctors. Just another of the many instances of the advances in medicine, wholly due to the fact that our physicians are the best trained in the world. Yet, there are those within this country who want to "regiment" medicine, thus effectually shutting off all incentive to that research that has done so much for the health of our country.

A big hullabaloo continues to be raised throughout the country because of the announcement that some four million of our young men had been rejected for Army service because of physical disabilities. That, of course, is a lot of men, but an analysis of the situation indicates that we are not so badly off as these figures might indicate. In the first place, about seven per cent of these rejections were due to *illiteracy*, certainly not a physical ailment. In many other cases, thousands upon thousands of them, the physical disability was so light as not to incapacitate the individual from performing the duties incident to industry and commerce, yet were of such a nature as to cause rejection for Army service. The neuroses also play an important part in these high rejection figures; it now is definitely established that an enormous percentage of our population, including our young men, are neurotic, to some degree. Time was when we expected to find these "neuros" in the upper age groups; now it seems that the younger age groups contribute to these totals to a large extent.

President's Page

Each month the preparation of this page has been a pleasant task. Whether the readers of THE JOURNAL have agreed or disagreed with the sentiments expressed here, or whether or not they have read the page at all, they have uniformly manifested the kindest respect toward the writer in his capacity as President. This has been most gratifying. The last page brings to mind the evanescent quality of human triumphs and the fleeting glory of elective office. We are merely noting the fact that the end of our task is in sight. We have no delusions of indispensability. We are glad to be free, and have no wish for a second term.

This has been a most eventful year. In addition to more than the usual activities, the society has been feverishly searching for some plan that will bring the practice of medicine into step with the rapidly changing economic conditions of the times. Many propositions have been brought forward, some of which have been seriously considered, but there are obvious difficulties in the way of all of them.

It was evident in the special session of the House that a majority of the delegates are in favor of some form of prepaid health insurance. A discussion of whether or not the society should own and operate such an insurance disclosed a wide difference of opinion. Much light can be shed on this question by the appointment of a larger and more diversified committee for its study. So far, the debate upon these plans has resulted in unity of action, which is far more important than any of the plans discussed.

The most serious difficulty with anything offered yet is the lack of experience in its operation. Only time can supply that lack. Perhaps we should not expect too much of any measure, but should consider only what is good for the doctor and his patient. Either we must stand still and wait for the processes of time to evolve a solution, or we must continue the study of various methods of ameliorating our situation.

The small cities and towns of Indiana do not have the same problems that are found in the thickly-populated districts. Measures to relieve the conditions in the industrial areas would mean little in rural districts of the state. Much valuable information has been compiled by the Committee for the Permanent Study of Health Insurance. This has been supplemented by the work of the Special Reference Committee on that report, but there is still a feeling that much information is needed before the state association commits itself to any course of action. We hope, therefore, that the committee which is to be appointed by the President, with the advice of the Council, will be made up of representatives from every councilor district, and from every one of the specialties, with a generous sprinkling of general practitioners, and that all of them may be men of good sense and sound judgment.

The report of such a committee, with further discussion in the House of Delegates, may disclose the answer to the question of pre-payment health insurance, and it may also furnish the remedy for many of the other abuses from which we suffer.

Zeophaunt

PROCUREMENT AND ASSIGNMENT SERVICE— WHERE DO WE GO FROM HERE?*

ELMER L. HENDERSON, M.D.

LOUISVILLE, KENTUCKY

Where the Procurement and Assignment Service goes from here depends entirely on the length of the war and the situation that develops in the course of the war. All of us are familiar with the activities of the Procurement and Assignment Service in securing enough physicians for the armed services. Equally important were the efforts of the service in maintaining adequate medical care for the home front. Utilizing a voluntary program, both of these objectives have been met.

Now, however, the civilian population has dispensed with about as many physicians as it can spare. The armed forces have about all the medical officers they can obtain, if not all they desire, and Procurement and Assignment Service is busily engaged in helping to facilitate a more equitable distribution of the physicians remaining at home, and attempting to spread the available personnel so that hospitals can have some appreciable proportion of their peacetime house staffs.

Since the Procurement and Assignment Service is a war agency, which presumably will not have tasks beyond the end of the war, consideration can be given only to those problems which will arise in the meantime. They will consist of continued and increased shortages alleviated to a small or great extent by those individual members of the profession who are demobilized prior to the cessation of hostilities. Being charged as it is with the task of looking out for the civilian population, it must of course, do everything it possibly can, on a voluntary basis, to see to it that such personnel returning to civilian life is most effectively utilized. The Directing Board of the Procurement and Assignment Service is at the present time giving consideration to these problems, and we will no doubt hear from them at an early date as to just what role the service will play between now and the end of the war with Japan. I wish it were possible for me to tell you how much better things are going to be as soon as hostilities in Europe cease. I also wish it were possible for me to bring a note of cheer and of hope for relief of the overworked civilian physicians, but in place of that I regret that I find it necessary to do as the politicians do, "view with alarm" the situation facing us. It is not clear when the organized or disorganized resistance in Germany will collapse, nor is it very clear what the status of the population in liberated countries will be. The conditions of the

civilian population in a defeated and occupied Germany are difficult to describe. Obviously, all of these factors will play an important part in the utilization and retention of medical officers in the armed forces.

The Army probably will not discharge physicians in proportion to discharges of the enlisted personnel, and therefore the number of people on the home front which the civilian doctors will have to care for is apt to increase before it can begin to decrease.

Secondly, the Navy, which has never come anywhere near meeting its complement of physicians, will continue, to a great extent, in full force for some time. The Army will continue, as far as can be determined at the present time, considerable activity and will probably desire to have for its remaining forces its full complement of physicians, which is about two per thousand more than at present.

In the third place, the Army will either continue to care for its own casualties or will refer such casualties to the care of the Veterans Administration. In either case, this task requires a very high ratio of physicians to patients.

Fourth, we have had an increasing death rate, and increasing incapacitation among the physicians left on the home front.

Fifth, the men coming out of the services indicate a desire for additional training, which will make them available to hospitals but not to civilian practice beyond the hospital.

Sixth, the Army may well use the newer graduates for replacements and take as high a proportion as they are taking at present, whether or not hostilities continue in Europe.

Seventh, there is now a good deal of talk about compulsory military training. If one and one-half million men enter the armed services for a year's service each year, they will require a continuous staff of ten thousand physicians to care for them while they are in the Army, without regard to the physicians who serve such individuals during the balance of their lives when they are at home.

Finally, it is worth while considering the increase in medical load that results from war. War takes the young and the healthy and makes of them the wounded and the sick. The Army going to war represents that portion of the population which needs less medical care than any other section of the civilian group. War returns this group to the civilian front as a section that needs the most, or at least nearly the most, medical attention. At any rate, they will need a great deal more medical

* Presented before the War Participation Luncheon at the annual meeting of the Indiana State Medical Association on Wednesday, October 4, 1944.

attention than if they had been in civilian life in the meantime rather than at war.

In this connection it must be pointed out that deaths and wounds will also occur in the members of the medical profession who are at war. This, added to the deaths and debilities occurring among the civilian practitioners because of their increased work-load, gives us a personnel which is less well equipped to take care of a population which needs more care. Too much emphasis has been placed upon the fact that for a brief period we have produced more than a normal number of physicians.

If you will give careful consideration to the points I have listed, you will see that they will be

quickly absorbed in the postwar picture. Added to this is the fact that we do not have at present a guaranteed continuing supply of material to matriculate in medical schools, and if you can view the situation with anything but "alarm," you must of necessity make entirely different interpretations of the facts than those which I believe are sound.

Let us hope for the best and prepare for the worst, and continue to function in our present task of distributing medical care so that the most effective utilization can be made of every member of the profession in this emergency.

NURSING CARE FOR THE WIVES AND INFANTS OF MEN IN THE ARMED FORCES

EDNA MOORE KUHN, R.N.*

ROBERT E. JEWETT, M.D.**

INDIANAPOLIS

The Emergency Maternity and Infant Care Program has been expanded in Indiana to include a limited amount of nursing care for the wives and infants of men in the four lowest pay grades of the United States Army, Navy, Marine Corps, and Coast Guard (including enlisted men in these grades who are deceased or missing in action). This program is to supplement and not to replace any nursing care already available and accessible to the wife or infant of a man in the armed service. Such care is provided without cost to the patient and without financial investigation.

A committee which was appointed by the executive secretary of the Indiana State Nurses' Association assisted representatives of the State Board of Health in the institution of this nursing plan. The following groups of nurses and nursing agencies were represented: Indiana State Nurses' Association, Hospital Superintendents of Nurses, Board of Nurse Examiners, private duty nurses, and public health nursing associations. The committee offered valuable assistance in the establishment of standards and fee schedules.

Individuals accepted for medical care under this program are referred routinely to local public health nursing agencies for nursing visits unless the attending physician requests that this patient not receive nursing supervision.

All nurses participating in this program must be registered or in the process of being registered in Indiana and must have had training and experience in maternity and/or pediatric nursing, as re-

quired by the Division of Public Health Nursing, Indiana State Board of Health. No provision is made in this plan for the services of a practical nurse.

The Division of Public Health Nursing, State Board of Health, is responsible for the establishment and maintenance of qualifications and standards of nurses from whom care is purchased. All reports of the nursing care are reviewed by the Maternal and Child-Health Nursing Consultant.

Types of Nursing Service Which May Be Authorized:

In a hospital, private duty nursing care during a period of critical illness may be authorized not to exceed four days, when such care cannot be provided by nurses employed in the hospital.

In the home, nursing care may be authorized on a visit basis by the staff of a voluntary public health agency, or by a graduate nurse when such nursing service cannot be made available by state or local public health agencies. The following types of care may be allowed:

(a) Visits to an antepartum patient who has complications and needs nursing care in order to carry out the specific orders of the physician, such as taking blood pressure, urinalysis, or giving special treatments or medications. This care is not to exceed six visits.

(b) A maximum of six visits to a mother while she is receiving bed care during the puerperium. If the mother is delivered at home, she may have the six visits; however, if she is discharged early from the hospital, the following visits are allowed:

1-3 days in the hospital—6 visits.

4 days in the hospital—5 visits.

* Maternal and Child-Health Nursing Consultant.

** Director of the Division of Maternal and Child-Health, Indiana State Board of Health.

5 days in the hospital—4 visits.

6 days in the hospital—3 visits.

7-8-9 days in the hospital—2 visits.

(c) Visits, not to exceed fourteen, to a sick mother (antepartum or postpartum) or sick infant who needs bedside nursing care.

(d) Nursing care throughout the period of labor and delivery.

(e) Private duty nursing care for the mother or infant during a period of critical illness not to exceed four days.

When the initial amount of care which has been authorized is not sufficient, the physician must request an extension of care from the Division of Maternal and Child-Health, State Board of Health, before the initial period of authorization expires.

Authorization:

Authorization for nursing service is granted only when the case has been approved for medical care by the Division of Maternal and Child-Health, State Board of Health.

No payment for service is made to a Visiting Nurse Association or Public Health Nursing Agency until an agreement has been signed by the agency and the State Board of Health.

The request for nursing service should be made on the proper form, or in emergencies this request may be made by phone or wire to the Division of Maternal and Child-Health. In the cases where there has been a delay in the application for medical care, if sufficient documentary evidence is sub-

mitted by the physician to allow the medical care to be authorized on a retroactive basis not to exceed six weeks, nursing care may be authorized to cover this retroactive period also.

Payment for Services:

Upon receipt of the completed report form and vouchers, payment is made directly to the nurse or nursing agency who has rendered the service. The nurse or nursing agency may not accept additional payment for services from or in behalf of the patient.

Fee Schedule:

Payment is made to the visiting nurse agencies at their local prevailing rates not to exceed \$1.65 per visit for a mother and baby, and \$1.40 per visit for a mother or baby.

A minimum fee of \$6.00, and 75 cents per hour or fraction of an hour after eight hours, is paid for assistance with a home delivery. For a lost call or false alarm, the fee is \$2.50 for two hours or less, and 75 cents an hour thereafter.

For private duty nursing in the home or hospital the local prevailing rates are allowed providing they do not exceed a maximum of \$7.00 for eight hours with no additional payment for meals, and a maximum of \$10.00 for twelve hours with no additional payment for meals.

Hourly nursing is allowed at the local prevailing rates not to exceed \$2.50 for the first hour and 50 cents for each additional hour. No additional payment is made for the care of the baby.

NURSE RECRUITMENT FOR THE MILITARY

The wounded at the battlefield cannot wait. . . . With the opening of more fronts, the casualty lists mount. The Army, therefore, needs more nurses. Instead of 10,000 by spring, the urgent need is 10,000 by January first.

Just a few months ago (last June) the Indiana Procurement and Assignment Service for Nurses was happy to report in *THE JOURNAL* of the Indiana State Medical Association that the state's quota for the first six months of 1944 had been exceeded, and that never had Indiana failed to reach its quota in enlisting nurses for the military. With these facts in mind, the stabilization of home-front nursing was emphasized. But now we come to the place where we must give more to the armed forces quickly and without dislocating the home front.

There is a war to win! And in war, orders are subject to change—constantly, if necessary. Casualties are mounting, and more nurses are now needed.

Word comes from General Norman T. Kirk, Surgeon General of the Army, that: "We go on the theory that whatever is asked for overseas must be provided. We now have 27,000 nurses overseas,

which leaves 13,000 at home. We will continue to send every nurse they ask for, even if it strips our hospitals in the United States."

A report from Miss Ethel R. Jacobs, R.N., Indianapolis, chairman of the Procurement and Assignment Service for Nurses, states that when the recent urgent call for additional nurses for the military came through, Indiana's quota was 203 by January first. Already, 49 have been recruited, leaving 154 needed to fill the quota. And obtaining the quota is not going to be easy. One out of six or seven nurses classified as 1-A is found to be eligible and willing to enter the service.

There are in the state approximately 10,000 nurses of all ages. More than 1,200 already are in the military, many of them having enlisted early, and others as quotas were filled. Of the 10,000 of all ages, there are 6,000 actively working in the state. Many of them, of course, are not eligible for the military. Likewise, some have married and retired. So the "pool" of nurses for the military is small.

As of late October, there were 4,833 nurses classified. There were 984 inactive, 165 available for relocation, 351 essential until replaced, 2,540 in

essential nursing activities, and 361 available for military service.

The recruitment of nurses for the military service is lagging seriously in Indiana, and throughout the nation. The hope of the military for nursing service are the nurses now graduating. It is urged that all of those classified as available for military service apply for military appointment before graduation, so that no time will be lost from school to the armed forces. It is pointed out that

these nurses will have to learn a new job, and they might as well learn in the Army or Navy. By so doing, they will help avoid further dislocations on the home front.

There were 616 senior nurses taking their State Board examination on November first. The Procurement and Assignment Committee feels that if ninety-one of them will volunteer for the military, the balance (sixty-three) could come from those now classified 1-A, thereby meeting the 154 quota.

PIONEER PHYSICIANS AND SURGEONS OF MONTGOMERY COUNTY, INDIANA

(This is a continuation of the article published in the May, September and November, 1943, and July and August, 1944, issues—Editor's Note.)

GEORGE T. WILLIAMS, M.D.

CRAWFORDSVILLE

Benjamin F. Hutchings, M.D., was born in 1846, and died at Crawfordsville, Indiana, in 1938. He graduated from the Ohio Medical College in 1872, and located in Waveland and New Market before coming to Crawfordsville in 1881. Through the many years of service to the public he was very successful. He was ethical toward the profession. A son, Dr. Merle Hutchings, a graduate of the Indiana Medical College in 1903, practiced with his father for two years, and then located in Terre Haute, Indiana, where he is practicing surgery, and is among those listed in *Who's Who Among Physicians and Surgeons*, published in 1938.

Isaac N. Brent, M.D., was born in 1845, and died at Crawfordsville, Indiana, in 1938. He was a graduate of the University of Louisville Medical School with the class of 1877. He was a former member of the United States Pension Board. He practiced in Jamestown, Indiana, for many years. After his health failed he moved to Crawfordsville and lived a retired life. He was a quiet, well-disposed man, making many friends during his residence here.

Benjamin F. Briggs, M.D., was born near Rochester, New York, in 1829. He studied medicine in his native town, and spent four years in medical research in Germany and France. Returning home, he graduated from the New York College of Physicians and Surgeons. He came to Crawfordsville in 1873, where he formed a partnership with Drs. McClelland and Barnett. He performed the first laparotomy done in Montgomery County, Indiana. In 1878 he moved to California, and died there in 1893.

Jesse Franklin Davidson, M.D., was born in Fountain County, Indiana, October 14, 1853, and died at Crawfordsville, March 30, 1934. He graduated from the Medical College of Indiana, in 1880, and began practicing his profession at Wal-

lace, Indiana, remaining there for six years. In 1886 he moved to Yountsville and remained there until 1893. He then came to Crawfordsville, and was one of the organizers of the Tribe of Ben Hur. He was elected chief medical examiner for the order, which position he held until the time of his death. Dr. Davidson was a good physician and endeared himself to his many fraternal and professional friends.

Charles H. Walden, M.D., was born in 1854, and died in New Market, Indiana, in 1917. He purchased a location from Dr. B. F. Hutchings, of New Market, in 1881, remaining there until his death. No record of date of graduation nor school has been found to date.

Irwin A. Detchon, M.D., was born in Indiana in 1850, and died at Crawfordsville in 1928. He graduated from the University of Pennsylvania in 1876. He practiced medicine a short time, then entered the drug trade with his father, Dr. Elliot Detchon. He had a pleasing personality and was courteous and obliging to all who came in contact with him.

William T. Batman, M.D., was born in 1858, and died in 1921. He was a graduate of Jefferson Medical College in 1880. He also received special instruction in New York City under Drs. Loomis, Thomas and Emmett, in 1884. He was vice-president of the Jefferson College Alumni; twice a delegate to the American Medical Association, and was elected auditor of Montgomery County for two terms. He first located at Roachdale, Indiana, then came to Ladoga, and then to Crawfordsville.

George P. Ramsey, M.D., was born in Crawfordsville, Indiana, February 18, 1876, and died there in November, 1921. He graduated from the Indiana Medical College in 1900. He was located in Newtown, Indiana, for six years; Whitesville three years; and at Crawfordsville until the time of his death. He served two years as county coroner.

William G. Swank, M.D., was born in 1860, and died at his home in Crawfordsville, Indiana, in 1936. He was a graduate of St. Louis Medical College and after graduation located in Crawfordsville. He was a member of the Montgomery County Medical Society and was city and county health officer for several terms. It was he who first advocated "city sanitation," and his warfare against filth and nuisances of every kind was aggressive. He was conscientious in his work.

Jacob R. Etter, M.D., was born near Putnamville, Indiana, March 16, 1852. He graduated from Indiana Medical College in 1876. After graduation he located in New Ross, Indiana, remaining there until 1883, when he came to Crawfordsville. He was a talented man. He invented a line of electric machines, and was an advocate of electric treatment for diseases. He died at his home here in 1924.

Paul J. Barcus, M.D., was born near Lafayette, Indiana, in 1862. He died at his home in Crawfordsville in 1925. He was a graduate of the Rush Medical College and was associated with Dr. Warren H. Ristine for a few years, and then took up general surgery. He was very successful and commanded a large patronage. He did the first cesarean section performed in this section of the country. He was a skillful operator, and the profession lost a conservative and skilled surgeon when he died.

Royal Hart Gerard, M.D., was born in 1875, and died in 1923. He was a graduate of the Medical College of Indiana with the class of 1899. He practiced in Crawfordsville all his life. After the death of his father, David W. Gerard, he was elected president of the Tribe of Ben Hur, and served as such until his untimely death in an elevator crash at Terre Haute in May, 1923.

Fred Atwood Dennis, M.D., was born in Indianapolis, Indiana, April 20, 1876, of Quaker descent. Early in his life the widowed mother came with her family to Crawfordsville, and he received his early education in the schools of this city. After his graduation from high school he began to read medicine with Drs. Gott and Taylor, and later attended the Indiana Medical College, graduating therefrom in 1898. He located in Alamo, Indiana, where he practiced until 1902, when he came to Crawfordsville, and enjoyed a good practice until his death in 1941. He was elected county coroner and also served as county and city health officer. He was a good physician and a true friend.

Herman E. Greene, M.D., was born in 1868, and died in 1922. He graduated from the University of Michigan in 1898, and began practice here after his graduation. He was a pioneer in eye, ear, nose and throat diseases. He was very successful. He did cataract operations in the home successfully before we had hospital facilities. He was a member of this society, and held the esteem and respect of the profession. Many of you remember him.

Our co-worker, Dr. Byron Lingeman, is successfully carrying on the work he began.

Henry William Taylor, M.D., was born in Lexington, Virginia, in the 1840's. During the Civil War he was a soldier for the South. After the war he began the study of medicine. In 1872 he settled in Crawfordsville, where he was a leading physician and surgeon. He was a prominent citizen, both from a literary as well as a political standpoint. He was a brother of the late Dr. John N. Taylor, of our city. He made many contributions to the press. The following is one of his poems included in a book of poems published by his wife after his death, in Sullivan, Indiana, on January 29, 1901, and which had been read before an association of doctors:

ARE THEY NOT KNIGHTS?

*"Are they not knights who thus take up
The gage of battle for God's poor,
And hold the shield of science broad
The meanest breast before,*

*"Are they not knights who, hoping not
Reward of gold or fame's sweet breath,
In many a desperate tilt, unsung,
Repulse the robber Death?"*

*"Are they not knights, who with bared heads
Confront the hosts of pestilence,
And when the Church anointed flees
Remain a sure defense?"*

*"For whom did knight of old break lance
But high-born dame or beauteous maid?
While for the maimed, the poor, obscure,
Are our great feats essayed.*

*"Not of an earth-born order we,
But knighted by that God-like hand
That sometimes made the blind to see
In Judah's storied land.*

*"And dying with the harness on,
What prouder fate could man befall
To answer 'Adsum Domine'
To the Archangel's call?"*

(HENRY WILLIAM TAYLOR.)

William De Caux Tilney, M.D., was born in Norwich, England, July 7, 1841. He served three years in India under British Government service. In 1867 he emigrated to the United States; in 1868 he graduated from the Philadelphia Medical School, and in 1887 he graduated from the Indiana Eclectic College of Medicine. He practiced as a local physician from 1871, in Crawfordsville, specializing in chronic diseases. He was a typical Englishman, genial, and jolly, and a strong prohibitionist. He died in 1925 at the age of eighty-four.

William Dunlap McClelland, M.D., was born in Montgomery County, Indiana, in 1851, and died in

Crawfordsville in 1915. He was a graduate of Miami Medical College with the class of 1875. He located in Chattanooga, Tennessee, and was there during the yellow fever epidemic. Shortly after that he returned to Crawfordsville, where he practiced for a time. Later he retired from the practice of medicine and entered into another field of work.

Austin A. Swope, M.D., was born at Stilesville, Indiana, in 1868, and died in Crawfordsville in 1937. He graduated from the Medical College of Indiana in 1898, and immediately located in Crawfordsville, where he practiced continuously until his death. He was a careful physician, was very popular, did a desirable business, and was kind to the poor. Dr. Swope was respected by the profession.

Harvey W. Sigmond, M.D., was born in 1871, and died in 1933. He graduated from the Louisville Medical College in 1898. He located in Crawfordsville, Indiana, and for four years or more he was associated with Dr. William T. Gott. He had a large general practice. He pioneered in electrotherapeutics and established an x-ray laboratory, and did extensive work along that line. He was an earnest student, well qualified in his chosen field in his day. Many of us remember him as the cheerful, optimistic "Sig." His passing was most untimely.

George E. Clements, M.D., was born in 1866, and died in 1935. In 1900 he graduated from Rush Medical College and located in Crawfordsville, Indiana, in 1902, where he pursued his growing practice. In 1911 he went abroad, taking postgraduate work in Berlin, returning in 1913. He was a good diagnostician, thorough in all his work and respected by the profession.

William T. Gott, M.D., was born near Ladoga, Indiana, in 1855, and died at Crawfordsville in 1933. He graduated from the Eclectic Institute of Cincinnati in 1880 and located in Crawfordsville, Indiana, where he had an extensive practice. In 1884 he did postgraduate work at the New York Polyclinic, and in 1903 at the London City Hospital, London, England. He was a member of the State Board of Medical Registration and Examination, serving as president of the board from 1898 to 1901, and was then elected secretary in 1901, serving in that capacity until his death. He was the first health officer elected in Montgomery County. He was a member of Governor Mount's staff, with the rank of colonel. He and Dr. J. C. Webster, of Lafayette, with a regular Army surgeon, conducted the examinations of physicians making application for service in the Spanish-American War. Many of you remember Dr. Gott. He was a splendid physician and surgeon.

John N. Taylor, M.D., was born in Harrisonburg, Virginia, in 1849. He died in Crawfordsville, Indiana, in 1935. He attended the University of Iowa and was graduated with first honors from the Indiana Medical College in 1878. He was one of the founders of the Sydenham Society, organized in 1875; wrote the constitution and by-laws, and was secretary of that society during his college term.

He was for many years a successful practitioner in Crawfordsville. The high standing which he attained in his profession was indicated by the fact that he was president of the International Health Association and of the Indiana State Board of Health. His devotion to his professional studies and duties prevented him from giving that attention to literature which his genius doubtless would have enabled him to do with success. He has, however, written much good verse, some of which will serve to commemorate his memory when his more practical toils are forgotten. I feel that no more fitting expression of our respect for these crusaders against disease and for the advancement of medical science can be given than to quote from a poem "The Crusader's Tomb," written by Dr. John N. Taylor, and published in *The Poets and Poetry of Indiana* in 1900:

"But his warfare is done, and he rests from his toil,
Where the winds nightly moan through the transept and aisle,
Where his warders stand grim in the long gathered gloom,
Where his hatchments are dim as they hang o'er the tomb.
And the soft, silvery moon on his helmeted head
Rests like a dream of a day that is dead."

(JOHN N. TAYLOR.)

ACKNOWLEDGMENTS

In a spirit of gratitude, I wish to acknowledge my indebtedness to the following, from which source I gained much of the data used in the preparation of "The Physicians and Surgeons of Pioneer Days," to wit:

- "Old Settlers," by Sanford C. Cox, 1823-1824.
 - "Beckwith's History of Montgomery County, Indiana," 1881.
 - "Bowen's History of Montgomery County, Indiana," 1913.
 - "Medical History of Indiana," G. W. H. Kemper, M.D., 1911.
 - "Indiana State Transactions of Medical Society," 1901, 1907.
 - "Transactions of the Pan-American Medical Congress," 1893.
 - "Shades of Death and Other Poems," writings of Dr. Joseph P. Russell with Biography, 1901.
 - "Who's Who Among Physicians and Surgeons," 1938.
 - "The White Druse and Other Poems," Henry W. Taylor, M.D., 1904.
 - "Poets and Poetry of Indiana," Parker and Heinley, 1900.
 - "The Family of Thomas Herron," 1755-1936, by Harriet Harding Millis and William A. Millis.
- I am also indebted to the families and friends of these pioneers who have contributed photographs and data.

I wish to state that this is not a complete nor

accurate list and record, but that it is as nearly so as I was able to make it with the data obtainable.

A goodly number have won a national reputation, many names also appear that are only locally known, and there are some whose memory has faded since our fathers and mothers have fallen asleep. If these are not to be ranked among the greater, they have at least helped to make the honorable history of our county and state.

ADDENDA

Milton G. Herndon, M.D., was born at Georgetown, Kentucky, September 20, 1801, and died at Crawfordsville, Indiana, June 3, 1872. He was for a number of years a practicing physician in Crawfordsville. He was also prominent in I.O.O.F. circles, being elected grand master of the Grand Lodge of Indiana in 1850, and elected deputy grand sire in 1860, and acted as grand sire in 1861 and 1862. A marker was erected at his grave in the I.O.O.F. Cemetery at Crawfordsville by the lodges of Indiana.

Samuel E. Jones, M.D., was born August 5, 1875, at New Richmond, Indiana. After graduation from the New Richmond High School he attended the Indiana State Normal College. For two years he taught school in Montgomery County. He attended the Indiana Medical School and was graduated in 1906 when the medical school was connected with Purdue University, and was placed on the honor roll of his class. In May, 1906, he entered the general practice of medicine at Bowers, Indiana, and was elected to the office of county coroner in 1906 for one term. In the fall of 1907 he moved to New Richmond and practiced there and at Kirkpatrick until the spring of 1910. From 1910 to 1920 he was located at Lucerne, Indiana. In 1920 he entered the Chicago Polyclinic Hospital for a special course in eye, ear, nose and throat work, and returned to Crawfordsville, where he specialized in this practice in 1921 and 1922. In 1924 he located in Indianapolis, where he practiced medicine until his death in 1937. Dr. Jones was assistant in the Department of Ophthalmology at the Indiana University School of Medicine. He had two sons who were graduates of this school, and one daughter, a graduate nurse.

Charles A. Caplinger, M.D., was born in Warren County, Indiana, September 12, 1863. He died at Wallace, Indiana, July 4, 1925. When quite young he went with his parents to Ladoga. The family later moved to New Market, where he spent his early manhood. For a number of years he practiced at Marshall. In 1901 he took up his residence in Wallace, where he lived until his death. He had a large practice in Fountain and western Montgomery counties for a number of years. He was highly esteemed as a physician, and was a Christian man.

Edward Howard Cowan, M.D., was born at Frankfort, Indiana, December 21, 1846. He died in Dallas, Texas, August 1, 1942. In 1862 he entered Wabash College and continued his studies there

until May 23, 1864, when he enlisted in the Army at President Lincoln's last call for volunteers, and served in Co. H, 135th Indiana Volunteers, under Captain McClelland, of Crawfordsville. On September 19, 1864, he was mustered out of service. At the close of the war he re-entered Wabash College, graduating in 1867. In 1868 he began the study of medicine with Dr. Moses Baker, of Stockwell. He later entered Miami Medical College, of Cincinnati, where he received his M.D. degree in 1873. In April, 1873, he began the practice of medicine in Crawfordsville, continuing for more than fifty years in active practice. He was a member of the American, state and county medical societies. He was the first city health officer, and served as a member of the Crawfordsville School Board. At the time of his death he was surgeon general of the Grand Army of the Republic, was Montgomery County's last surviving Civil War veteran, and was believed to be the last survivor of the Wabash College Roll of Honor of Students and Alumni who served in the Union Army during the Civil War.

Aubrey Leighton Loop, M.D., was born in Boone County, Indiana, November 18, 1874. He attended Indiana Medical College, graduating in 1899. He located for the practice of medicine at Economy, Indiana, remaining there until 1919 when he came to Crawfordsville, and continued in active practice until his death, September 5, 1942. During World War I he served as a member of the United States Army, in the Medical Department, with the rank of first lieutenant. He served as county coroner for two terms. Dr. Loop enjoyed a good practice and was highly esteemed by the profession and the community at large, being a cultured and Christian man.

Warren Henry Ristine, M.D. (retired physician), was born February 3, 1850. He graduated from Bellevue Medical College in 1877. After graduation he located at Crawfordsville, where he practiced continuously for fifty-seven years. He is now retired and spends the winters in Florida and the summer months at his home on West Wabash Avenue. Dr. Ristine is highly esteemed by the profession and is remarkably preserved, both physically and mentally, for one at his time of life. The profession extends to him its cordial greetings with the hope that he may enjoy the choicest blessings that can be bestowed upon a faithful follower of Aesculapius.

James L. Beatty, M.D. (retired), was born in 1859. He graduated from Miami Medical College, Cincinnati, in 1881. He located in New Market, Indiana, after graduation and later moved to Crawfordsville. Later he again returned to New Market, where he continued practice until his retirement in 1939. Dr. Beatty is highly esteemed in the community he served so long and so faithfully, and by the profession in general. He is an honest, capable and conscientious physician.

Fay O. Schenck, M.D. (retired), was born in 1878. He graduated from the Medical College of Indiana in 1905. He immediately located at Craw-

fordsville, and continued in practice until his retirement in 1922. Dr. Schenck's retirement (because of ill health) was a loss to the profession and the community which he served.

Clement C. Collins, M.D., was born in 1870. He graduated from the Kentucky School of Medicine in 1892. He was located in Roachdale during all of his professional life. He died in 1940.

Samuel Peacock, M.D., was born in 1868. He graduated from the Medical Department of the University of Buffalo in 1892. His entire professional life was spent at Ladoga, Indiana.

Edward C. Lidikay, M.D., was born in 1877. In 1903 he graduated from the Medical College of Indiana. After graduation he located at Ladoga, Indiana, and continued practice there until his death about 1936.

N. Austin Cary, M.D., was born at Burlington, Indiana, August 2, 1882. After graduation from high school, at Petroleum, he attended the Fort Wayne College of Medicine for two years, and the Indiana Medical College, graduating in 1906. He began the practice of medicine at Silver Lake, Indiana, in 1906, and came to Crawfordsville in 1912. He entered the military service by way of the National Guards in 1916, with the rank of major, M.C., and was discharged in 1919 with the rank of lieutenant colonel, M.C. After a year spent at Johns Hopkins University, Baltimore, Maryland, he moved to Oakland, California, where his practice was limited to orthopedic surgery. He retired from active practice in 1936.

Robert M. Foster, M.D., was born April 3, 1871, and died December 29, 1919. He graduated from the Louisville Medical College in 1902, and located at Russellville, Indiana, where he did an ever-increasing practice until the time of his death. He left a son, Dr. Ruel J. Foster, who is in practice at New Philadelphia, Ohio.

Floyd N. Shipp, M.D., was born in 1878. After graduation from the Crawfordsville High School he entered the College of Physicians and Surgeons, at Indianapolis, from which he graduated in 1903. He served in World War I from 1917 to its close. He was located for a few years in Crawfordsville, and died in 1939.

PHOTOGRAPHS OF PHYSICIANS IN CASES*

1. Ball, Zopher (1832-1895).
2. Barcus, Paul J. (1862-1925).
3. Batman, William F. (1858-1921).
4. Beatty, James L. (1859), retired.
5. Berry, John William (1855-1881).
6. Brent, Isaac N. (1845-1938).
7. Bounell, Matthew H. (1828-1896).
8. Bronaugh, Charles Tinsley (1854-1934).
9. Brown, Alonzo Fry (1865-1910).
10. Brown, Iral T. (1826-1907).
11. Brown, Rylan T. (1807-1890).
12. Brown, Theodore F. (1844-1919).
13. Burroughs, William H. (1849-1907).
14. Caplinger, Charles A. (1863-1925).

15. Chambers, William Beaty (1856-1910).
16. Clements, George E. (1866-1935).
17. Collins, Clement C. (1870-1940), Roachdale.
18. Cowan, Edward Howard (1847-1942).
19. Davidson, Jesse Franklin (1853-1934).
20. Dennis, Fred Atwood (1876-1941).
21. Detchon, Elliot (1828-1905).
22. Detchon, Irwon (1850-1928).
23. Dewey, George W. (1844-1924).
24. Dickerson, James W. (1853-1921).
25. Dunnington, Reuben C. (1851-1906).
26. Eddingfield, George W. (1844-1926).
27. Ensminger, Samuel L. (1844-1921).
28. Etter, Jacob R. (1852-1924).
29. Ensminger, John S. (1859-1900[?]).
30. Fine, Ephraim N. (1844-1903).
31. Fitch, Alexander Peter (1845-1918).
32. Florer, Thomas Wilson (1822-1907).
33. French, John S. (1829-[?]).
34. Gaston, John M. (1818-1901).
35. Gerard, Royal Hart (1875-1923).
36. Gott, William T. (1855-1933).
37. Green, Samuel John (1817-1894).
38. Greene, Herman E. (1868-1922).
39. Griffith, Martha E. H. (1842-1923).
40. Griffith, Thomas J. (1837-1923).
41. Hall, George Washington (1869-1941).
42. Hall, Stephan A. (1864-1937).
43. Hamilton, Albert N. (1847-1926).
44. Henry, Abijah H. (1835-1898).
45. Herron, Richard D. (1813-1885).
46. Hurt, William Johnson (1850-1919).
47. Hutchings, Benjamin F. (1846-1938).
48. Irwin, Samuel G. (1825-1907).
49. Jameson, Patrick H. (1824-1910).
50. Johnson, Walter L. (1842-1928).
51. Jones, Oliver H. (1843-1915).
52. Jones, Samuel E. (1875-1937).
53. Keegan, Enoch W. (1836-1914).
54. Kelso, Reese D. (1866-1896).
55. Kleiser, Arthur J. (1862-1942).
56. Layne, Preston M. (1827-1917).
57. Lidikay, E. C. (1877-1939[?]).
58. Loop, Audrey L. (1874-1942).
59. May, Willis L. (1828-1900).
60. Mahorney, J. C. (1851-1905).
61. Montague, Fred T. (1840-1894).
62. Morgan, Samuel B. (1813-1886).
63. McClelland, Alfred (1811-1862).
64. McClelland, James S. (1821-1875).
65. McClelland, William Dunlap (1851-1915).
66. McNutt, Samuel D. (1827-1860).
67. McMechan, James Garven (1808-1899).
68. Niven, J. S. (1869), now in Texas.
69. Olin, Leverett W. (1851-1924).
70. Olinger, David F. (1835-1893).
71. Orear, John Henry (1822-1891).
72. Peacock, Norman (1873-1936).
73. Peacock, Samuel (1868-[?]), Ladoga.
74. Price, Ezra (1866-[?]) Ladoga.
75. Ramsey, George P. (1876-1921).
76. Reed, David (1867-1938), Russellville.
77. Rhea, James O. (1874-1938).
78. Riley, Charles W. (1867-1937).
79. Rogers, Henry Clay (1844), now at Rockville.
80. Rich, Fanny McClelland (1842-1921).
81. Ristine, Warren Howard (1850), retired.
82. Russell, Joseph P. (1815-1893).
83. Sigmond, Harvey W. (1871-1933).
84. Schenck, Fay O. (1878), retired in 1922.
85. Sloan, John Jay (1811-1883).
86. Steele, William Wakefield (1860-1898).
87. Steele, Armstrong T. (1834-1884).
88. Steele, Jordan Samuel (1833-1873).
89. Straughan, John W. (1831-1911).
90. Straughan, Kent K. (1857-1926).
91. Swank, William G. (1860-1936).
92. Swope, Austin A. (1868-1937).

* (Collected and placed in the Culver Union Hospital by George T. Williams, M.D., Crawfordsville, Indiana, on October 15, 1942.)

93. Talbott, Jesse N. (1840-1908).

94. Taylor, Henry W. (1844-1903).

95. Taylor, John N. (1849-1935).

96. Tilney, William D. (1841-1925).

97. Thompson, William F. (1852-1928).

98. Utter, Joseph R. (1847-1914).

99. Van Cleave, Charles L. (1867-1898).

100. Van Cleave, William Edgar (1877), now in Oklahoma.

101. Walden, Charles H. (1854-1917).

102. Wilhite, Mary H. (1831-1923).

103. Wilson, John B. (1830-1907).

104. Wishard, William N., Sr. (1820 [?]).

105. Sparks, Joseph Tyndall (1853-1926).

PROCUREMENT OF PHYSICIANS FOR ARMED FORCES

November 3, 1944.

The War Department Army Service Forces has issued a directive, copy of which has been sent to C. R. Bird, M.D., chairman of the Procurement and Assignment Service for Indiana, as follows:

"The War Department has announced that the number of physicians now on active duty with the Army, augmented as necessary by the calling to active duty of those already commissioned and those in established training programs, *no longer necessitates the withdrawal of additional physicians from civil life.* The commissioning of physicians from civil life has, therefore, been discontinued except for those whose services are required by the Veterans' Administration.

"The applications of all physicians in various stages of processing at the time of the War Department announcement are being presented to the Veterans' Administration for consideration for appointment as officers of the Army for duty with that agency. Because of the War Department's announced policy and, since the Veterans' Administration has not requested your appointment, no further action with regard to your application will be taken by this service.

"The excellent co-operation of the medical profession and your unselfish tender of service in this emergency are greatly appreciated by the War Department."

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASE CONTROL
MONTHLY REPORT—SEPTEMBER, 1944

DISEASES	Sept. 1944	Aug. 1944	July 1944	Sept. 1943	Sept. 1942
Chickenpox	35	11	20	32	20
Measles	9	16	52	39	21
Scarlet Fever	100	55	79	79	67
Smallpox	3	1	0	0	3
Typhoid Fever	13	13	18	10	21
Whooping Cough	52	62	105	171	150
Diphtheria	35	18	20	26	19
Influenza	14	6	18	17	42
Pneumonia	6	3	12	23	47
Mumps	22	9	31	20	14
Poliomyelitis	108	108	49	37	25
Cerebrospinal Meningitis	5	10	15	5	2
Nonepidemic Meningitis	1	0	0	0	0
Trachoma	4	2	2	0	0
Tetanus	1	0	1	0	1
Tularemia	1	0	1	0	0
Undulant Fever	2	6	17	6	3
Malaria	5	10	4	1	0
Rocky Mt. Spotted Fever	2	2	6	3	0
Rabies in Man	1	0	1	0	1
Conjunctivitis	2	3	0	0	0
Rubella	2	0	2	4	3
Septic Sore Throat	4	0	2	3	0
Vincent's Angina	3	0	2	0	2
Erysipelas	1	2	0	0	0
Tuberculosis, Pulmonary	264	365	241	88	147
Tuberculosis, Other Forms	9	11	6	22	11

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASE CONTROL
Monthly Report—October, 1944

DISEASES	Oct. 1944	Sept. 1944	Aug. 1944	Oct. 1943	Oct. 1942
Chickenpox	90	35	11	205	120
Measles	13	9	16	186	47
Scarlet Fever	137	100	55	281	204
Smallpox	2	3	1	2	1
Typhoid Fever	11	13	13	12	12
Whooping Cough	42	52	62	109	138
Diphtheria	40	35	18	66	36
Influenza	9	14	6	28	63
Pneumonia	10	6	3	34	84
Mumps	18	22	9	49	123
Poliomyelitis	37	108	108	27	17
Cerebrospinal Meningitis	12	5	10	23	1
Trachoma	3	4	2	1	0
Tularemia	1	1	0	0	0
Food Poisoning	1	0	0	0	0
Undulant Fever	4	2	6	8	4
Amoebic Dysentery	1	0	0	0	0
Encephalitis, Lethargic	1	0	2	2	0
Malaria	2	5	10	12	1
Septic Sore Throat	3	4	0	2	0
Silicosis	14	0	0	0	0
Impetigo	4	0	1	0	0
Tuberculosis, Pulmonary	327	264	365	326	124
Tuberculosis, Other Forms	15	9	11	43	27



Military News



Dr. W. J. Aagesen, of Anderson, has been promoted from major to lieutenant colonel, according to a release from the War Department.

Major Wendell L. Spalding, of Mishawaka, is in a hospital in India, recovering from tropical diseases. He reported that Captain Floyd T. Romberger, Jr., of Lafayette, has called on him.

Major W. D. Close, of Indianapolis, recently has been home on a thirty-day leave after having been stationed in Iceland for the past two and one-half years.

For meritorious service on the field of battle in France, Lieutenant Colonel Robert E. Daniels, of Decatur, has been awarded the Bronze Star. Colonel Daniels has been serving overseas since last November as a divisional surgeon.

Congratulations to Dr. Dan L. Urschel, of Mentone, who has been promoted to a captain. Captain Urschel is on duty at the Battey General Hospital, at Rome, Georgia.

Major W. J. Fagaly, of Lawrenceburg, has been transferred to the Wakeman General Hospital, at Camp Atterbury, Indiana. He was previously at Nichols General Hospital, in Louisville, Kentucky.

Lieutenant (jg) Woodson C. Young, of Indianapolis, is at the Personnel Depot at San Bruno, California.

In the limited space on one of those V-mail change-of-address cards, Major Willard C. Smullen, of Rushville, writes: "Major James Pebworth, Captain Emory Hall, and I are all in the same outfit. Quite an Indiana bloc." Major Smullen gives no clue as to his whereabouts other than that he has a new San Francisco A.P.O. address.



Lieutenant Colonel Cyrus J. Clark, of Indianapolis, who is on duty with the Indiana General Hospital, sent a Christmas card with greetings written in French. On the card Colonel Clark wrote: "Just a little remembrance from France, to wish you a Very Merry Christmas and a Very Happy New Year. Tell everyone 'hello,' and that we all are fine."

Merry Christmas to you, Colonel Clark!

Captain James G. Shanklin, of Hammond, has left Rosecranz Field, and is now with the Army Air Force in Brazil, South America.

The latest address for Captain Otis R. Lynch, of Marengo, is Fort Warren, Wyoming.

Lieutenant Colonel Parvin M. Davis, of New Albany, has been transferred from the Gorgas Hospital, Ancon, Canal Zone, to the station hospital at Fort Lawton, Washington.

Captain George K. Hammersley, of Frankfort, has left Camp Breckenridge, Kentucky, for an overseas destination. Captain Hammersley is at present chief orthopedic surgeon with a general hospital.

Captain Orville A. Hall, of Muncie, is stationed in the Caribbean area. He has been in the Army Medical Corps since June, 1942, and has been serving in that area since December, 1943.

Major Carl J. Langenbahn, of South Bend, is now in France, living in the usual manner—pup tent and tinned rations. He seemed anxious to move on to working quarters and get to work.

Captain William H. Lane, of South Bend, who is with the Indiana General Hospital, has written that they have been in France since the last of July, but that he did not get to work before the first of September. The hospital was set up in a tent, but they are now building permanent quarters, and hope to have them finished before it gets too cold. He says his work consists of giving spinals. The nurses take care of the other anesthetics.

After transferring from Italy to Southern France, Captain James W. Ward, of Mishawaka, states that he prefers France because of the greater cleanliness and friendliness, although he entered both countries with the invasion forces.

THE JOURNAL office was pleased to receive a visit from Major Joseph O. Flora while he was in Indianapolis recently on a two-week leave. Major Flora said that since September eighteenth he has been at Fort Jackson, South Carolina, where he is with the medical attachment of an infantry regiment. His duty at present is to train replacements for overseas, officers as well as others. Major Flora spent thirty-one months in the Aleutian Islands prior to his present post, and stated without hesitation that Indiana is by far a better place.

MAJOR HAGGARD MISSING IN ACTION

It is with extreme regret that we report that Major Gordon B. Haggard, of Hope, has been listed as missing since October seventh. Major Haggard was a flight surgeon with a heavy bombardment group, and is listed as missing in action over Germany.

The troop carrier unit for which Major Harold C. Adkins, of Indianapolis, is group surgeon, was recently awarded a unit citation for successfully landing glider and parachute troops in Normandy on June fifth, sixth, and seventh under adverse weather conditions.

Major C. B. LaDine, of Indianapolis, is now stationed in France. He is on duty as executive officer of a general hospital, but is with Patton's Third Army not far from the front lines. At the time of the last report, Major LaDine was living in a tent in an area that had not long been abandoned by the Germans, and was not far from the spot where fifty French hostages from a nearby town had been shot in retaliation for the death of one German officer. Major LaDine has been overseas since August, 1942, and was first stationed in Iceland, coming from there to England, and then to France.

In a letter to Mr. Hendricks, Lieutenant Commander John W. Ferree, who is now in Seattle, Washington, states: "The day after I last saw you in Indianapolis I received orders to report out here as V.D. control officer for the Thirteenth Naval District. I am liking the duty and the Northwest very much. My family is with me, and despite the housing shortage we were able to find a lovely place through a very good break. It was good to learn that the annual meeting of the state association approved the post-war plans of the State Board of Health. There is much to commend them.

"Will you please change my address for THE JOURNAL to the above? That last number was a 'lulu.' My best regard to the working staff."

From France, Captain Thomas Younan, of Lafayette, writes: "Some months ago, while in Italy, south of Pisa with the Fifth Army, my A.P.O., unit, and location were changed when I received a transfer order from another headquarters. As a result I made the invasion of southern France in the vicinity of Toulon. Ever since we have come a long way from the Riviera coastline. This is my fifth campaign in two years of overseas service—from Casablanca to France, and to a half-hour's ride from 'Kraut Land.' I have enjoyed my experiences so far, but am not begging for any encores.

"I enjoy your 'MedSoc' V-mails, and read THE JOURNAL from cover to cover during spare moments. We see over one thousand patients and casualties daily."

After spending twenty-six months at Fort Thomas, Kentucky, Captain James M. Alexander, of Argos, has been transferred to the Darnell General Hospital, at Danville, Kentucky. Captain Alexander states that all his work in the Army has been limited to neuropsychiatry.

We wish to quote from a letter from Lieutenant B. W. Thayer, of North Vernon, who writes: "After a short tour of duty at the Aiea Naval Hospital, Pearl Harbor, in 1942 and 1943, I spent the rest of the year, and January of 1944, with the Marines and gooney birds on Midway Island.

"Returning to the States, I attended the Naval School of Aviation Medicine at Pensacola, graduating May twenty-fifth. Since that time I have been aviation medical examiner for the Dallas office of the naval officer procurement."

We quote herewith a recent letter from Captain Philip J. Rosenbloom, of Gary: "It may surprise you, but I flew down the other day to a general hospital here, and there amongst the literature in the day room was 'ye good olde Indiana Medical Journal,' and thus having awakened a nostalgia, I felt I would write and thank you for the 'MedSoc' letters, et cetera. They are marvelous for our morale—I just can't wait until I get home (rotation, centrifuging, or otherwise).

"As you can see by the address, through the usual Army 'Snafu'—(upon leaving the States, a clerk dropped the limited service after my name). I arrived in New Guinea a full general service soldier, and despite my age and infirmities was assigned to this active combat unit on the furthestmost outpost of Dutch New Guinea. So, I am now an infantryman, a foot-slogger, working as a surgeon in a clearing company with a portable surgical hospital attached.

"We have been through three actions so far. Two were rather mild, but the second one was somewhat 'ruff, ruff.' But really, I'm happy here, because for the first time since I entered service I'm doing that type of work for which I enlisted.

"Out here, in this substitute for hell, we fight not only the enemy, but disease, bugs, heat, humidity, and boredom. Nothing to do and no place to do it. It's hard to keep from going 'jungle happy,' so I whittle on block palm and write lousy poetry, which I will *not* inflict upon you.

"Things are quiet up here now except for daily patrols with the usual net of starving Jap prisoners and the regular air-raids. In fact, we are supposedly 'in garrison,' but no one has told Tojo this so he comes over as usual, and what the general thinks he is dropping on us is more than I can fathom; they are not bon-bons!

"Besides our own medicine and surgery, we treat the natives in their villages, and always see yaws, malaria, scrub typhus, trachoma, filariasis, and leprosy—all the diseases we were not taught."



This is the Taj Mahal, said to be the most perfect building in the world. It was built in the Seventeenth Century. The picture was taken by Major Ivan W. Scott, who recently returned from India.

Major Ivan W. Scott, of Indianapolis, who has been stationed in India for many months, recently returned by air. Major Scott did not have a great deal to say about the trip *over*, with the exception that he left on such short notice that he did not have time to do any packing, and consequently crossed the equator twice wearing a woolen uniform; but he was quite enthusiastic about his return trip by plane, stating that it was the most exciting part of his trip overseas. While we cannot tell the actual route, Major Scott did see many of the world's historical places.

Most of his time overseas was spent at a general hospital located a few miles from the desert. Major Scott explained that he realized there are many worse places where one could be stationed, although it was very hot and sunbaked there, with the sands blowing continuously, and that there was a high incidence of tropical diseases. Their living quarters were better than they had expected (they took tents with them), being quarters that had originally been built for British troops. Outside of movies, the only amusements were of the kind they themselves could provide, but they found much enjoyment in camel riding, and boating, which was possible since they were close to the ocean. Major Scott never met any Indiana physicians while in India, but he did meet First Lieutenant Valina Boyd, an Indiana University Hospital graduate, who he believes is

the only Indiana nurse in the China-Burma-India theatre. Of all the nurses sent to them when their hospital was converted from a station to a general hospital, Lieutenant Boyd was the only nurse to receive a promotion, which is indeed a credit both to her and to the University.

For two months Major Scott lived with three other officers in Calcutta, in a veritable palace staffed with nine servants. The price—\$1.50 per day, including their food. And speaking of food, the chef was a "European chef" who previously had served a rajah, and who concocted such things as meringue and sugar sailboats for dessert. But in the Army the good things never last, so Major Scott descended from this paradise to the hot, scorched, desert.

There are many things that remain untold, many experiences that cannot be told. In fact, Major Scott had written up one particularly intriguing experience in story form. It was so intriguing that the censor showed profound interest in it, and begged to be allowed to read it, stating that he couldn't return it until after the war. And, well, you know wartime restrictions, the story is still in—, shall we say "Shangri La," for wartime security.

Major Scott has reported to Miami Beach for reassignment. Best of luck, doctor, wherever you go!

Lieutenant A. C. Remich, of Hammond, who is stationed with a field hospital somewhere in France, wrote as follows: "I am enjoying THE JOURNAL more every month since I have been overseas, probably because I have more time to concentrate on it. Your 'MedSoc' letters are very welcome, too. Do you think that there is any question but what Indiana Medicine is excellent and the society progressive? After comparing notes, I'm glad to belong to this society." We thank you, Lieutenant Remich, for your fine letter, and we are hoping that the time will not be long before you—all of you—can take a more active part in our association affairs.

We quote herewith a letter from Captain Phillip E. Yunker, of Evansville: "Well, the old Hoosier 'Docs' are spread all over the face of the globe. I am now assigned to this station hospital, and it couldn't be better. Have a very good physical plant as well as a fine staff. Have a rather rapid turnover, and a capacity of about twelve hundred beds. Have, indeed, been fortunate in having been able to do professional work ever since I've been in this man's army, and hope I may have the good fortune of continuing to do so.

"I have time occasionally for a swim in the Pacific, and to take little expeditions. I have seen the native festivals and dances, and villages. I arrived here at the end of the rainy season, and now it is starting in again. They say December, January, and February are the worst. The days and nights stay the same length the year around."



Major Scott at the entrance to the Taj Mahal.



Major Scott and his camel-uaala

Major Scott dressed as a British officer.



This office has received a letter from Captain Sydney Norwick, of Indianapolis, and upon reading it we noticed several places where the ink was blurred. Captain Norwick explains this by saying, "The weather in the low countries being what it is, I can't even find a windmill that is dry enough to keep stationery from getting wet. I have been battalion surgeon with this unit in Sicily, and throughout these operations, and immodestly I can claim this unit the most spectacular of any in the whole Army. I have had much contact with civilian doctors because I've been as much as one hundred miles ahead of an evacuation hospital. The doctors in northern France and in Belgium have modern approaches and high standards of practice. They are very cooperative, too."

The following information has been received from the headquarters of the European Theater of Operations, United States Army:

"Lieutenant Colonel Orval J. Miller, former physician and surgeon of Fort Wayne, is now commanding officer in charge of a United States General Hospital, in England, an institution having a bed capacity as large or larger than the biggest metropolitan hospitals in the United States. Wounded from the battlefields of France comprise the vast majority of patients now under the care of Colonel Miller and his organization.

"I have been highly gratified," he declared, "in learning that our long period of training in the states has equipped us to come in and take over an established institution of this kind, and keep it going without interruption."

"Given command of the unit in June, 1943, when it was activated as a station hospital in training at New Orleans, Louisiana, Colonel Miller has directed the training program which fitted this organization for overseas duty. The medical group was reactivated as a general hospital unit shortly after being moved to Fort McClellan, Alabama, in December, 1943, where an intensive program of training for the present assignment was inaugurated.

"Officer personnel has been assigned to us with high regard for the professional qualifications of each individual," Colonel Miller said. "In practically every instance the officers in my command are specialists in their own particular field. Many members of the nursing corps with us have also been given special training in the care and handling of the sick and wounded in this type of hospital."

"Colonel Miller is enthusiastic when he speaks of the supplies and equipment available for carrying on the work in the hospital. 'We have a complete supply of drugs and medicines, including the latest sulfa derivatives and penicillin,' he explained, adding, 'Our equipment is of the latest type and compares very favorably with that to be found in any big hospital back in the States. There is nothing in the medical or surgical field that we cannot do here.'

"High in his praise of the work being done by the enlisted men in his command, Colonel Miller said, 'I have a warm place in my heart for the enlisted men. They are actually doing the work in this hospital, and they are doing it well. Were it not for them and the way they have assimilated their training, we would not be able to carry on.'

"Entering the Army as a first lieutenant, Colonel Miller was assigned to duty at Camp Croft, South Carolina. His first medical administrative assignment was at that post, where he was appointed detachment commander of the station hospital complement. From that duty he was promoted to Chief of Medical Service, and later became executive officer, advancing in rank to Lieutenant Colonel."

Recently a letter has been received from Colonel E. L. Bergquist, who was formerly the Command Surgeon of the Troop Carrier Command at Stout Field, but who is now overseas. He writes: "Received your invitation to attend the October session of the Indiana State Medical Association, but didn't have time to get there since it arrived today. Hope you had a good meeting, and I certainly wish I had been there.

"I have joined the Royal Society of Medicine in London. It is quite an interesting outfit.

"Regards to all my friends there."

Colonel Bergquist, we, too, are sorry that you couldn't attend our meeting.

A very clever letter written by Captain John E. Fisher, of Clarksburg, who is stationed in India, has been received by "MedSoc," and we "10-derly" quote it herewith:

"Dear MedSoc:

"For the past six months the Army Directory Service has been informing me that, 'Regulations require you to notify your correspondents immediately of your correct address.' Apparently they have no means of knowing I haven't had a correct address during that time, so please note the present address.

"I assure you that I am looking forward to receiving 'MedSoc's' V-mail each month, and without as much delay as I have had to experience recently.

"My present camp is pleasant, reminding one of a modified summer resort. The grass is green and there are many nice shade trees with small barracks buildings scattered among them. There are several small lakes—or to be more accurate, ponds or mud holes—around the area. The natives use them for drinking, bathing, laundry, and washing the cows and buffalo—in the reverse order.

"The barracks are made of brick and then plastered over so that they look like stucco, and have the usual thatched roof. I think that mine isn't going to leak too much. Of course, there are plenty of termites, lizards, ants, mosquitoes, et cetera, both inside and outside the barracks. However, we have been able to keep the jackals and sacred cows on the outside. Each of us have a native bed which has cotton webbing instead of springs. They aren't like home, but are much better than sleeping on the ground. The shower is about fifty yards behind my barracks, which is quite convenient. I go over there twice a day to check on the water—not to determine the temperature, but to see if there is any water. There was some three days ago. As for the temperature, it is always the same.

"We have a nice officers' club which is open each evening. There is a reading room which no one uses, and a barroom which is complete with indirect lighting, tables and chairs, overhead fans, a phonograph, and walls well decorated with paintings. The drinks are quite reasonable in price and unreasonable in their action, being made from native whiskey, gin, or rum. Most of us stick to our P.X. ration beer.

"My place of business was formerly used as an Enlisted Men's Club, and therefore has paintings on the walls. . . . I seem to be getting more men to come in to see me each morning, but after they look around the room they don't seem to be nearly as sick as when they came in. Over my desk is a wonderful ceiling fan which is run from a generator. The generator is run three times a day, at mealtime. You can't get ahead of this Army.

"Hoping you are the same, I remain,

"Yours 10-derly,

"(Signed) John E. Fisher."

News Notes

Dr. Joy F. Buckner has established an office in Bluffton for the practice of his profession. He was formerly located at North Manchester.

Dr. M. C. Topping, of Terre Haute, has been re-elected as chairman of the Vigo County Chapter of the International Infantile Paralysis Foundation.

Dr. Paul Jarrett, of Muncie, has taken over the office of Dr. William D. Hart, of Muncie, for the practice of medicine. Doctor Hart is now in the armed forces.

Dr. R. N. Bills and Miss Garnett Campbell, both of Gary, were married October fifth in Chicago. Following a short trip to South Dakota Doctor and Mrs. Bills have returned to Gary where they will make their home.

Dr. A. C. Corcoran and Dr. Robert D. Taylor, both of the Lilly Clinic at the Indianapolis City Hospital, will resign their positions there to accept appointments at the Cleveland Clinic the first part of next year.

In addition to his duties as president of the Richmond Board of Health, Dr. Harry P. Ross has been appointed as a member of the State Board of Health. Doctor Ross will succeed the late Dr. Henry C. Metcalf, and will serve the unexpired portion of the term to which Dr. Metcalf was appointed. The term expires December 6, 1945.

Dr. Wayne L. Ritter, a major in the United States Public Health Service, has been appointed director of the Industrial Hygiene Division of the Kentucky State Board of Health. Doctor Ritter, who is from Indianapolis, previously had been assigned to the development of health and safety measures in defense plants in Mississippi.

MEETING OF THE INDIANA ASSOCIATION OF THE HISTORY OF MEDICINE

A meeting of the Indiana Association of the History of Medicine will be held at eight o'clock, Friday evening, December eighth, in Parlor E at the Lincoln Hotel.

Dr. James O. Ritchey, of Indianapolis, will talk on "Doctor Books," which is a fitting subject in connection with the History of Medicine.

Everyone interested in the History of Medicine should avail himself of the opportunity of hearing this talk—guests are invited.

The Knox County Medical Society recently contributed funds to provide for a sun deck on the roof of the nurses' home at the Good Samaritan Hospital, in Vincennes. This gift will provide the nurses and student nurses with much needed recreation.

Dr. Howard Hogan is a new full-time member of the staff of the Cameron Hospital, in Angola, having recently returned to this country after nineteen months' foreign service. Doctor Hogan served as a lieutenant colonel in the Medical Corps, and is now on inactive duty. Prior to his entrance into the Army, Doctor Hogan was engaged in private practice in New York City. He will limit his work at the Cameron Hospital to hospital consultation and practice.

UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed \$500" for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. The selected essay (or essays) will appear on the program of the forthcoming June meeting of the American Urological Association. Essays must be in the hands of the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1945.

RED CROSS SHIPS PENICILLIN BY AIR FOR PRISONERS OF WAR IN GERMANY

On the basis of recommendations by medical officers recently repatriated from German prison camps and hospitals, the American Red Cross has sent five thousand tubes of penicillin by air express to the International Red Cross Committee in Geneva, to be used for American prisoners of war held by Germany. The International Committee has been asked to keep the prison camp leaders informed of the medicines available in the stocks held in Geneva for their use, and to suggest that the leaders not allow camp stocks to become depleted before reordering. Regular shipments of Red Cross first aid kits intended for use when doctors are not available have been made to the prison camps in Germany. Bulk shipments of medicines and medical supplies also have been made to supplement those provided by German military authorities for the care of sick and wounded prisoners of war.

Dr. Emanuel C. Liss, formerly of Columbus, Ohio, has opened an office in South Bend for the practice of medicine. Doctor Liss will practice pediatrics and the treatment of children's allergies.

CHICAGO MEDICAL SOCIETY CLINICAL CONFERENCE

Tuesday, Wednesday, and Thursday—February 27, 28 and March 1, 1945—are the big days, the days on which Midwestern physicians can take advantage of the educational opportunity offered by the excellent scientific program and the carefully-selected commercial and scientific exhibits to be presented during the Annual Clinical Conference of the Chicago Medical Society, at the Palmer House, Chicago.

The program of these three days, of intensive post-graduate medical education, will be replete with the names of widely-known and well-recognized, local and national, medical educators, men who will present a wide variety of currently interesting medical topics. The program being arranged will be of real interest to all physicians, general practitioners, and specialists alike. The presentations begin at 8:00 A.M. and continue all day throughout the three days, with a special program Tuesday evening, and with a well-planned banquet program Wednesday evening.

Those who attended the First Annual Clinical Conference, last March, will not need any urging to return for the second Conference; those who did not attend will be equally enthusiastic if they take the time to attend the next session—it will be worth their while. Make your hotel reservation with the Palmer House, at Chicago, now!

INDIANA UNIVERSITY NEWS NOTES

The appointment of Dr. Theodore Makovsky, of Valparaiso, graduate of the Indiana University School of Medicine, to a Fellowship in Pathology for research in cancer, has been announced by Dean W. D. Gatch. The fellowship is provided by the Indiana Field Army, of the American Cancer Society, and provides \$1,400 a year for three years. The study will be made through the Cancer Clinic, at the University's Medical Center in Indianapolis.

General Hospital No. 32, recruited and organized at the Indiana University Medical Center, is doing its part in reducing the number of deaths from war wounds, according to letters received from members of the hospital staff. Commissioned in June, 1942, and made up of doctors, dentists, and nurses recruited under the sponsorship of the Indiana University Medical Center, the hospital is a successor to Base Hospital 32 similarly recruited in World War I. Censorship regulations do not permit publication of its whereabouts, but the hospital unit recently received commendation for its services.

Dean W. D. Gatch, in his capacity as president of the Western Surgical Association, will give the presidential address at the opening of the association's two-day meeting December first, in Chicago.

Dr. Robert J. Masters, chairman of the Department of Ophthalmology in the Indiana University School of Medicine, at Indianapolis, has been made a member of the National Board of Ophthalmology, which acts as a certifying agency in that field. He has for a number of years been a member of the Diseases of the Eye Section of the American Medical Association, and has been head of the Eye Department of the University's School of Medicine since July, 1943.

More than fifty physicians of Lafayette and vicinity have been reported by Dean Gatch to be taking advantage of the postgraduate instruction provided through the recently-established affiliation of St. Elizabeth's Hospital, of Lafayette, with the Indiana University School of Medicine. The affiliation arrangement which is expected to be expanded soon to take in other leading hospitals of the state is designed for postgraduate training, particularly of residents and internes, but also is open to practicing physicians. Members of the school of medicine faculty and staff conduct monthly meetings at St. Elizabeth's Hospital.

Members of the senior class in the Indiana University School of Medicine, who by reason of their Army status will be called to field duty after graduation in December, are getting at least preliminary interne training through the resident clerkship program instituted last May. Twenty-eight members of the class are assigned to the Indianapolis City Hospital, and an equal number to the university hospitals. The emergency character of cases handled by the City Hospital provides students with clinical material not available at the university hospitals. The resident clerkship program will be supplemented, beginning this week, with weekly symposiums for discussions by resident staffs, x-ray technicians, and clinicians.

Establishment of an orthoptic clinic, at the James Whitcomb Riley Hospital, of the Indiana University Medical Center, to add to the center's facilities for the treatment of eye troubles of Indiana children, has been announced by Dean Gatch. The clinic will have as its technician Miss Marie Louise Falender, of Indianapolis, who under a scholarship provided by Dr. Robert J. Masters, chairman of the Indiana University Medical School's Department of Ophthalmology, recently concluded nine months of training under Dr. Conrad Behrens, noted ophthalmologist, at the New York Eye Infirmary. Special training will be provided by the clinic for children having difficulty in eye focusing, and the training will supplement surgery for correction of crossed eyes.

Dr. L. E. Napier, director of the Calcutta School of Tropical Medicine, was the speaker at the Clinico-Pathological Conference, held at the Indiana University School of Medicine on November tenth. Dr. Napier spoke on "Tropical Diseases of India." He has been invited by the National Research Council to give similar lectures in various schools of medicine throughout the United States. The program is financed by a grant from the John and Mary R. Markle Foundation to the National Research Council.

Fear that the present shortage of doctors may continue after the war are groundless, in the opinion of the country's medical school heads, as disclosed by Dean W. D. Gatch, of the Indiana University School of Medicine, following attendance at the annual meeting in Detroit of the Association of American Medical Colleges. "It is the general

opinion of the country's medical school deans that there will be no shortage of doctors after the war," said Dean Gatch. "There is, however, a fear that the continuing discussion of a possible shortage may lead to the setting up of wild-cat medical colleges by promoters who hope to cash in on the expanded demand for medical care after the war." He explained that the existing medical colleges, despite staff shortages, have carried on at an accelerated pace through the war period, producing medical graduates as competent as those trained in peacetime, and in larger numbers through accelerated programs. Civilian admissions to medical schools for classes opening in December and early next year are down due to the call to military service of pre-medical students, but the shortage is expected to be made up by assignment of quotas from the military services. The Army and Navy each has reserved a definite number of places in the forthcoming medical school classes.

Deaths

William D. Bonifield, M.D., of Warren, died November eighth at his home. He was eighty-two years of age. Doctor Bonifield was a graduate of the Medical College of Ohio, in Cincinnati, in 1888.

Robert M. Copeland, M.D., of Vevay, died October twenty-eighth at his home. He was eighty-three years of age. Doctor Copeland was a graduate of the College of Physicians and Surgeons of Baltimore in 1888. He had practiced for fifty-six years in Switzerland County and was still in practice at the time of his death. He was secretary of the Switzerland County Medical Society, having served in that capacity for many years. Doctor Copeland was also an honorary member of the Indiana State Medical Association and a member of the American Medical Association.

Earnest Craig McDonald, M.D., of Indianapolis, died October twenty-third at the age of forty-two. After graduating in 1931 from the Indiana University School of Medicine, he established an office in an Indianapolis suburb where he practiced for twelve years. Doctor McDonald served three years in the first World War. He was a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Guilford Dudley Mottier, M.D., of Patriot, died September twenty-eighth at the age of seventy-one. He was a graduate of the Miami Medical College, in Cincinnati, in 1900. Doctor Mottier had retired from practice.

Albert Edward Sabin, M.D., of Dana, died suddenly on October twenty-sixth at the age of seventy. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1897. Doctor Sabin served as a physician in the first World War. He was a member of the Parke-Vermillion County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

Milton Madison Wells, M.D., of Fairland, died October twelfth after an illness of seven months' duration, at the age of seventy-three. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1901, and had been in practice in Fairland for forty years. Doctor Wells served as a first lieutenant in the Medical Corps in World War I. He was a member of the Shelby County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

Clyde Mansford Zink, M.D., of Clinton, died recently at his home after an extended illness. He was fifty-seven years of age. He was a graduate of the University of Louisville School of Medicine, in 1913, and was especially interested in Otorhinolaryngology. Doctor Zink was a veteran of World War I, and began the practice of medicine in Clinton in 1920. Doctor Zink had served as mayor of Clinton, and as coroner of Vermillion County for three years. He was also a member of the Parke-Vermillion County Medical Society, the Indiana State Medical Association, and the American Medical Association.

POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of December, 1919)

This number of THE JOURNAL contained but one scientific article, "Treatment of Tetanus, with Report of Six Cases," by Charles G. Beall, M.D., of Fort Wayne. Several of the succeeding pages were used to describe the Indiana University School of Medicine and the Robert W. Long Hospital, both of which buildings had recently been completed and occupied.

* * *

The lead editorial was entitled "The Slaughter of Teeth and Tonsils," a subject on which Editor Bulson frequently — and wisely — commented. He felt that too many of these organs were being needlessly sacrificed, blaming the physicians and dentists, together, for the wholesale extraction of teeth.

* * *

"Traitors and Disloyalists" also came in for a sane discussion. (It will be remembered that following World War I there was considerable discussion of this subject, and it seems that our editor wished to speak his mind on the subject.)

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The work of the Council on Pharmacy and Chemistry of the American Medical Association was reviewed, and due credit was given this group for what they were accomplishing.

* * *

It was announced that in a forthcoming issue of THE JOURNAL a complete record of all Indiana physicians engaged in war services would be published.

* * *

Doctor Thomas Barker Eastman had died at his farm home, near Richmond. "Doctor Tom," as he generally was known, was a son of Joseph Eastman, one of the pioneer surgeons of Indiana, and the brother of the late Joseph Rilus Eastman. "The Eastmans," father and two sons, were known throughout the land as leading surgeons of their time.

* * *

It was again suggested that measures should now be taken to enact a full-time health officer law, at the next session of the general assembly, this to apply to all counties having a population of twenty thousand or more.

* * *

One of the popular weekly magazines of the time remarked that a bacteriologist in one Berlin hospital received an annual salary of \$1,250, while the man who cleaned his instruments received \$1,500. This is somewhat like the situation applying in certain sections of this state, where school janitors receive a higher pay than some of the teachers.

New medical books were appearing in the advertising pages, most of them having a war-experience slant.

* * *

The coal shortage was still in evidence, causing no little inconvenience to those who in former years had been prudent enough to lay in a season's supply well in advance of the cold of winter. (Yes, we could get coal, one ton at a time, sidewalk delivery, by going to the office of the man in charge and getting a permit to buy that one ton.)

* * *

It was suggested that a campaign be waged to enroll every eligible physician as a member of his local county medical society. At the same time, it also was suggested that, by some hook or crook, it would be just as well to drop those members who were of no particular advantage to the society — chaps who attended no meetings and did nothing constructive.

* * *

Then as now there was a noticeable shortage of paper, and this, coupled with the manpower shortage in the print shops, caused frequent delays in getting out THE JOURNAL.

* * *

Dr. Floyd T. Romberger had removed his office from Elizabethtown to Lafayette.

* * *

Physicians returning from wartime services were: Charles R. Bird, of Greensburg; George Marshall, of Nappanee; W. S. Givens, of Indianapolis; Otto Casey, of Terre Haute; F. L. Hasman, of Indianapolis; O. B. Norman, of Bedford; J. S. Sprowe, of Lafayette; and Eugene Buehler, of Indianapolis.

* * *

The new Bloomington Hospital had been opened for the reception of patients.

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In October of 1919, there was but one death reported from influenza, while in this same month during 1918 four hundred thirty such deaths were reported.

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The Kosciusko County Memorial Commission had reported that it was their unanimous belief that a hospital would be the most practical memorial to the soldiers and sailors of that area.

* * *

Vigo County Commissioners had purchased one hundred thirty-five acres of land, located eight miles north of Terre Haute, for a new County Tuberculosis Hospital.

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION—1944

Following is a list of the members of the Indiana State Medical Association, including the names of all those who were members on November 8, 1944. Membership established after that date could not be included in this issue of *THE JOURNAL*. Members are listed in the county in which they hold their membership.

An asterisk (*) precedes the names of physicians who are in service in the armed forces.

Military addresses, for obvious reasons, are not published in this list. If the addresses of your friends appearing in the list below are not known to you, call the Indiana State Medical Association, FRanklin 3627, and if the addresses are known here they will be given to you.

The letter (H) following a name indicates that the physician is an honorary member of his local society and of the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to *THE JOURNAL*, 1017 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

Name	City	County	Name	City	County	Name	City	County
*Aagesen, W. J.	Andersca	Madison	*Anderson, Walter C.	Terre Haute	Vigo	*Bailey, L. S.	Zionsville	Boone
Abel, J. A.	South Bend	St. Joseph	*Anderson, W. C.	Rockville	Parke-	Bailey, Paul P.	Fort Wayne	Allen
*Abell, Charles F.	Marion	Grant			Vermillion	*Bailey, P. W.	Fort Wayne	Allen
Acker, Robert B.	South Bend	St. Joseph	*Andrews, C. L.	Greenfield	Hancock	Bailey, W. A.	Vincennes	Knox
Aere, R. R.	Evansville	Vanderburgh	*Andrews, D. Lee	Louisville, Ky.	Marion	Baltinger, H. M.	Gary	Lake
Adair, Wm. K.	Crothersville	Jackson	Annis, H. B.	Bluffton	Wells	Bakemeier, O. H.	Indianapolis	Marion
Adams, C. J.	Kokomo	Howard	Anthoulis, George D.	Gary	Lake	Baker, A. M.	New Albany	Floyd
Adams, D. S.	Indianapolis	Marion	*Appel, R. H.	Indianapolis	Marion	Baker, C. S.	Evansville	Vanderburgh
Adams, J. R.	Fort Wayne	Allen	Applegate, A. Earl	W. Lafayette	Tippecanoe	Baker, G. D.	Crandall	Harrison
Adams, Julia L.	Muncie	Delaware-	*Applegate, F. M.	Corydon	Harrison	Baker, Herman	Evansville	Vanderburgh
		Blackford	*Arbogast, John L.	La Fayette	Tippecanoe	Baker, J. S.	Evansville	Vanderburgh
Adams, M. R.	Flora	Carroll	Arbogast, P. B.	Vincennes	Knox	Baker, J. V.	Edinburg	Johnson
Adams, W. B.	Muncie	Delaware-	*Arbuckle, Russell	Indianapolis	Marion	*Baker, Leslie M.	Muncie	Delaware-
		Blackford	Arbuckle, Wm. E.	Indianapolis	Marion			Blackford
Ade, C. H.	La Fayette	Tippecanoe	Arford, R. D.	Middletown	Henry	Baker, Milan D.	Culver	Marshall
Ade, Mary	La Fayette	Tippecanoe	Arisman, R. K.	South Bend	St. Joseph	Baker, Robert E. (H)	Orleans	Orange
*Adkins, H. C.	Indianapolis	Marion	*Arlook, Theodore D.	Elkhart	Elkhart	Baker, Warren	Westville	LaPorte
*Adler, Raymond N.	Evansville	Vanderburgh	Armington, C. L.	Anderson	Madison	Baker, W. H.	South Bend	St. Joseph
Aiken, M. M.	Plainfield	Hendricks	Armington, John C.	Anderson	Madison	Bakes, Fred C.	Vevay	Switzerland
*Ake, Loren	Cambridge City	Wayne-	*Armington, Robert	Anderson	Madison	*Baleh, James F.	Indianapolis	Marion
		Union	Armstrong, T. D.	Michigan City	La Porte	Baldridge, E. R.	Terre Haute	Vigo
Aker, Charles L.	Greencastle	Putnam	Arnett, A. C.	La Fayette	Tippecanoe	*Baldridge, W. O.	Terre Haute	Vigo
*Albertson, F. P.	Trafalgar	Johnson	*Arnold, Aaron L.	Indianapolis	Marion	Baldwin, John H.	Jeffersonville	Clark
Alburger, Henry R.	Indianapolis	Marion	*Arnold, Ralph D.	Ligonier	Noble	Ball, Clay A.	Muncie	Delaware-
Aldrich, Harry	Fort Wayne	Allen	Arnold, Ralph N.	Greenfield	Hancock			Blackford
*Aldrich, Harry	Indianapolis	Marion	*Aronson, Sidney S.	Indianapolis	Marion	Ball, Thomas Z. (H)	Crawfordsville	Montgomery
Aldrich, Howard	Indianapolis	Marion	Arthur, H. M.	Hazletton	Gibson	Balla, Morris	South Bend	St. Joseph
Aldridge, J. W.	Covington	Fountain-	Arthur, N. Maude	Washington	Davies-	Ballard, C. A.	Logansport	Cass
		Warren			Martin	Ballard, Robert J.	Lebanon	Boone
Alexander, H. H.	Princeton	Gibson	Asbury, W. D.	Terre Haute	Vigo	*Ballenger, W. E.	Richmond	Wayne-
*Alexander, J. E.	Evansville	Vanderburgh	*Ash, H. H.	West Lafayette	Tippecanoe			Union
*Alexander, J. M.	Argos	Marshall	Asher, E. O.	New Augusta	Marion	*Balsbaugh, George	N. Manchester	Wabash
Alexander, O. O.	Terre Haute	Vigo	Asher, James W.	New Augusta	Marion	*Baltes, Joseph H.	Fort Wayne	Allen
Alexander, P. M.	Martinsville	Morgan	Ashworth, L. N.	Connersville	Fayette-	Banister, R. F.	Indianapolis	Marion
Alexander, W. P. (H)	Gary	Lake			Franklin	*Banks, H. M.	Indianapolis	Marion
*Allen, F. K.	Fredericksburg	Washington	Aspy, J. A. M.	Indianapolis	Marion	Barelay, I. C.	Evansville	Vanderburgh
Allen, H. R.	Indianapolis	Marion	*Atcheson, Bellfield	Gary	Lake	*Eard, Frank B.	Crothersville	Jackson
Allen, Hubert E.	Richmond	Wayne-	Atchison, K. C.	Rockport	Spencer	Barnard, P. C. (H.)	Parker	Delaware-
		Union	Atkins, C. C.	Rushville	Rush			Blackford
Allen, J. L.	Greenfield	Hancock	Atkinson, C. W.	Woswell	Benton	Barnes, Helen B.	Greenwood	Marion
*Allen, Lionel H.	Bedford	Lawrence	*Auerman, C. J.	Montpelier	Delaware-	*Barnett, R. E.	Peru	Miami
Allen, Orris T.	Terre Haute	Vigo			Blackford	*Barnett, Wm.	Logansport	Cass
Allenbaugh, A. E.	Evansville	Vanderburgh	*Austin, Eugene W.	Anderson	Madison	Barnum, Emerson	Shelbyville	Shelby
Almquist, C. O.	Gary	Lake	Austin, F. H.	Bloomington	Monroe	*Baron, E. A.	La Porte	La Porte
Altier, W. H.	Fowler	Benton	Austin, M. A.	Anderson	Madison	Barrow, John H.	Dale	Spencer
Alvis, E. O.	Indianapolis	Marion	Austin, R. P.	Bedford	Lawrence	Barry, M. J.	Indianapolis	Marion
*Ambrose, J. C.	Noblesville	Hamilton	Ayling, E. K.	South Bend	St. Joseph	*Bartle, J. Leo	Knightstown	Henry
Ames, George (H.)	Eaton	Delaware-	Ayres, Kenneth D.	Anderson	Madison	Bartley, D. A.	Indianapolis	Marion
		Blackford	*Ayres, W. W.	Hartford City	Delaware-	Bartley, Max D.	Indianapolis	Marion
					Blackford	Bartholomew, A. C.	Fort Wayne	Allen
Amick, Charles L.	Wakarusa	Elkhart	Bachrach, Moritz	South Bend	St. Joseph	Bartholomew, Mary	Goshen	Elkhart
Amos, E. M. (H)	Indianapolis	Marion	Backer, H. G.	Ferdinand	Dubois	*Barton, W. M.	Centerville	Wayne-
*Amos, R. L.	New Castle	Henry	Badders, A. C.	Portland	Jay			Union
Amstutz, H. Clair	Goshen	Elkhart	*Bazan, C. N.	Portland	Wells	Bascomb, Marshall R.	Calumet City,	
Amy, W. E.	Corydon	Harrison	Bahr, Max A.	Indianapolis	Marion		Ill.	Lake
*Anderson, C. P.	Gary	Lake	*Bailey, E. B.	Linton	Greene	*Baskett, R. J.	Jonesboro	Grant
Anderson, D. W.	Evansville	Vanderburgh		Logansport	Cass	Bass, F. E.	Shelbyville	Shelby
Anderson, R. J.	Indianapolis	Marion				Bassett, Clancy	Thorntown	Boone
Anderson, R. M.	Vincennes	Knox						

Name	City	County	Name	City	County	Name	City	County
Bassler, C. R.	Mishawaka	St. Joseph	Blakwell, S. R.	Gary	Lake	Boys, F. F.	East Chicago	Lake
Bassett, Margaret	Bloomington	Monroe	Blaize, J. L.	New Castle	Knox	Bradfield, J. C.	Logansport	Cass
Batman, F. H.	Bloomington	Monroe	Bland, Curtis	(Long Beach, Calif.)	Vigo	Bradley, Stephen C.	Terre Haute	Vigo
Batman, G. W.	Indianapolis	Marion	Bland, H. E.	Fairbanks	Sullivan	Brady, Samuel	Gary	Lake
Bauer, A. J.	La Fayette	Tippecanoe	*Blatt, A. E.	Indianapolis	Marion	Braginton, Fred	Hammond	Marion
Baum, J. R.	Warsaw	Kosciusko	*Blazey, A. G.	Washington	Daviess-	Brandman, Harry	Whiting	Lake
*Baumgart, E. T.	Indianapolis	Marion			Martin	Brauchla, C. H.	Anderson	Madison
Baumgartner, Jeraldine	Harlan	Allen	*Bledsoe, J. G.	New Castle	Henry	Brauer, A. A.	East Chicago	Lake
*Baumrucker, George O.	Indianapolis	Marion	*Blenker, Russell	Greensburg	Decatur	Braun, B. D.	East Chicago	Lake
Baxter, James W.	New Albany	Floyd	Blessinger, Paul J.	Jasper	Dubois	Braunlin, Robert F.	Marion	Grant
*Baxter, J. W., Jr.	New Albany	Floyd	Blinks, E. G.	Michigan City	Lake	Braunlin, W. H.	Marion	Grant
*Baxter, Neal	Bloomington	Monroe	Bloemker, E. F.	Indianapolis	Marion	Braunsdorf, R. L.	South Bend	St. Joseph
*Baxter, Samuel M.	New Albany	Floyd	Blood, R. P.	Hebron	Porter	Brayton, John R.	Indianapolis	Marion
Bayley, R. H.	La Fayette	Tippecanoe	*Bloom, Asa Ward	Marion	Grant	Brayton, Lee	Indianapolis	Marion
Beach, Robert R.	Indianapolis	Marion	Bloomer, J. R.	Rockville	Parke-	Brazelton, O. T.	Princeton	Gibson
*Beamer, G. D.	Delphi	Carroll			Vermillion	Brendel, O. E.	Zionsville	Boone
*Beams, Ralph H.	Fairmount	Grant	*Bloomer, R. S.	Rockville	Parke-	*Brenner, Andrew M.	Winchester	Randolph
Bear, L. H. (H)	Vevay	Switzerland			Vermillion	Brenner, I. E.	Winchester	Randolph
*Beard, Paul H.	Indianapolis	Marion	Blosser, B. A.	Fremont	Steuben	Bretz, W. D.	Huntingburg	Dubois
Beardsley, F. A.	Frankfort	Clinton	Blosser, H. V.	Fort Wayne	Allen	Brickley, H. D.	Bluffton	Wells
Beasley, T. J.	Indianapolis	Marion	Blossom, Paul W.	Richmond	Wayne-	Bridge, M. L.	Van Buren	Grant
Beatty, Norman M.	Indianapolis	Marion			Union	*Bridwell, Edgar	Delphi	Carroll
*Beaver, Ernest R.	Indianapolis	Marion	Blum, Leon L.	Terre Haute	Vigo	Briggs, C. F.	Sullivan	Sullivan
Beavers, S. D. (H)	Decatur	Adams	Boardman, Carl	Gary	Lake	Briggs, J. H.	Churubusco	Whitley
*Beeltold, S. E.	South Bend	St. Joseph	Boaz, John J.	Indianapolis	Marion	Brink, C. C.	Gary	Lake
Beek, Evert M.	Indianapolis	Marion	*Boerger, Victor L.	Fort Wayne	Allen	Brink, John C.	Detroit, Mich.	Lake
Beek, H. A.	Lebanon	Boone	Bogardus, C. R.	Austin	Scott	Briscoe, C. E.	New Albany	Floyd
Beeker, Philip H.	Crown Point	Lake	Boggs, E. F.	Indianapolis	Marion	*Britton, W. D.	Indianapolis	Marion
Beekes, Ellsworth	Vineennes	Knox	Bogue, W. J.	Monrovia, Calif.	Wabash	Broek, Earl E.	Anderson	Madison
Beekman, H. F.	Indianapolis	Marion	Bohner, C. B.	Indianapolis	Marion	*Brodie, Donald W.	Oaklandon	Marion
Bedwell, Marion H.	Sullivan	Sullivan	Bolin, J. T.	Hammond	Lake	*Brody, Arthur	East Chicago	Lake
Beeler, Bruce H.	Evansville	Vanderburgh	*Bolin, Robert S.	Goshen	Elkhart	Bronson, Paul J.	Terre Haute	Vigo
Beeler, R. C.	Indianapolis	Marion	*Bolling, R. L.	Indianapolis	Marion	*Brookie, Roger W.	Flora	Carroll
*Beetem, L. F.	Madison	Jefferson	Bolka, B. J.	South Bend	St. Joseph	Brooks, H. L.	Michigan City	La Porte
Beggs, L. F.	Columbus	Bartholomew	Bond, Charles S. (H)	Richmond	Wayne-	Brosius, Robert H. W.	Fort Wayne	Allen
Behn, W. M.	Gary	Lake			Union	*Brother, Geo. M.	Indianapolis	Marion
*Beierlein, Karl	Fort Wayne	Allen	Bond, George S.	Indianapolis	Marion	*Brown, A. E.	Indianapolis	Marion
Belden, L. D.	Indianapolis	Marion	Bond, Walter	Clay City	Clay	Brown, C. W.	Rolling Prairie	La Porte
Bell, D. W.	Ottwell	Pike	Boner, G. W.	Butlerville	Jennings	*Brown, D. B.	Gary	Lake
Bender, Cecil K.	Goshen	Elkhart	Bonfield, H. F.	Warren	Huntington	Brown, D. E.	Indianapolis	Marion
Bendler, C. H.	Gary	Lake	Booher, Irvin E.	Connersville	Fayette-	Brown, Edward A.	Indianapolis	Marion
Benham, James W. (H)	Columbus	Bartholomew			Franklin	Brown, Frances T.	Indianapolis	Marion
Benham, Shirley	Port Angeles, Wash.	La Porte	*Booher, Norman R.	Indianapolis	Marion	*Brown, J. C.	Valparaiso	Porter
*Bennett, J. B.	Warren	Huntington	Booher, Olga	Indianapolis	Marion	Brown, J. S.	Carlisle	Sullivan
Benningshoff, D. R.	Fort Wayne	Allen	Boone, John C. (H)	South Bend	St. Joseph	Brown, Karl T.	Muncie	Delaware-
Benz, Jesse	Marengo	Crawford	Bopp, D. W.	Whiting	Lake			Blackford
*Benz, O. F.	Whiting	Lake	Bopp, Henry W.	Terre Haute	Vigo	*Brown, K. H.	New Albany	Floyd
Beresford, G. B. (H)	Owensville	Gibson	Borders, Theo. R.	Fort Wayne	Allen	*Brown, M. S.	Spencer	Owen
Berger, Henry I.	Indianapolis	Marion	*Boren, Paul	Poseyville	Posey	Brown, R. E.	Cayuga	Parke-
Berghoff, Raymond	Fort Wayne	Allen	Boren, Samuel W. (H)	Poseyville	Posey			Vermillion
*Berke, Robert	South Bend	St. Joseph	Borland, R. M.	Bloomington	Monroe	Brown, R. R.	Terre Haute	Vigo
*Berkebile, J. B.	Peru	Miami	Bosenbury, C. S.	South Bend	St. Joseph	*Brown, Robert	Marion	Grant
Berman, J. A.	Indianapolis	Marion	Bosler, Howard A.	Nigeria, West Africa	Elkhart	Brown, S. L.	Hammond	Lake
Bernheimer, H. L. (H)	Terre Haute	Vigo	Boselmann, C. C.	Fort Wayne	Allen	*Brown, Wendell E.	Indianapolis	Marion
Bermoske, D. G.	Michigan City	La Porte	Bostwick, James G.	Mishawaka	St. Joseph	*Browning, J. S.	Indianapolis	Marion
Berns, P. C.	Linton	Greene	Bothwell, C. G.	Martinsville	Morgan	*Browning, W. M.	Indianapolis	Marion
*Bernstein, Joseph	Indianapolis	Marion	Bottorf, David C.	Charlestown	Clark	Brubaker, E. H.	Indianapolis	Marion
Berry, David F.	Indianapolis	Marion	Boulware, J. P.	Bloomington	Monroe	Brubaker, Harold S.	Huntington	Huntington
Bethea, D. A.	Hammond	Lake	Bourell, E. G.	Hillsboro	Fountain-	Brubaker, O. G.	N. Manchester	Wabash
Beverland, M. E.	Indianapolis	Marion			Warren	*Bruegge, T. J.	Kokomo	Howard
Bibler, Henry E.	Muncie	Delaware-	Bourell, Harry M. (H)	Waynetown	Montgomery	Bruetsch, Walter L.	Indianapolis	Marion
		Blackford	Bowdoin, G. E.	Elkhart	Elkhart	Bruggeman, H. O.	Fort Wayne	Allen
*Bibler, L. D.	Indianapolis	Marion	Bower, Daniel L.	San Marino	Calif.	Brumer, C. H.	Greenfield	Hancock
Bice, Lon C.	Edinburg	Johnson			Marion	Brumer, Ralph	Jeffersonville	Clark
Bickel, David A.	South Bend	St. Joseph	*Bowers, Copeland C.	Kokomo	Howard	*Bryan, F. A.	Indianapolis	Marion
Biekel, J. E.	Fort Wayne	Allen	Bowers, Don D.	Indianapolis	Marion	Bryan, Kathryn M.	Logansport	Cass
Bieknell, G. F.	East Chicago	Lake	Bowers, G. T.	Fort Wayne	Allen	Bryan, S. L.	Evansville	Vanderburgh
Bierly, Fred	Elizabeth	Floyd	*Bowers, John A.	Kokomo	Howard	*Buehanan, W. D.	Bremen	St. Joseph
Bigelow, O. P.	Roanoke	Huntington	*Bowers, J. W.	Fort Wayne	Allen	Buehe, F. P.	Richmond	Wayne-
Bigger, W. M.	Hammond	Lake	Bowles, J. H.	Muncie	Delaware-			Union
Bigham, J. C.	Batesville	Ripley			Blackford	Buekley, E. P.	Jeffersonville	Clark
*Bigsby, Frank L., Jr.	Evansville	Vanderburgh	*Bowman, Charles M.	Albion	Noble	Buekner, Doster	Fort Wayne	Allen
*Bill, Robert O.	Indianapolis	Marion	Bowman, George W.	Indianapolis	Marion	Buekner, Joy F.	N. Manchester	Wabash
Billman, G. S.	Shelbyville	Shelby	Bowman, I. E.	Odon	Daviess-	*Buehner, F. W.	South Bend	St. Joseph
Bills, L. F.	Gary	Lake			Martin	Buehl, Robert F.	Indianapolis	Marion
Bills, R. N.	Gary	Lake	Boyd, C. L.	Vineennes	Knox	*Buhmester, H. C.	La Fayette	Tippecanoe
Bird, Charles R.	Indianapolis	Marion	Boyd, Charles S.	East Chicago	Lake	Bulkstra, C. K.	Evansville	Vanderburgh
*Birdzell, J. P.	Crown Point	Lake	Boyd, Clarence E.	West Baden	Orange	Bullard, M. J.	Gary	Lake
Birmingham, P. J.	South Bend	St. Joseph	Boyd, David A., Jr.	Indianapolis	Marion	Bulson, E. L.	Fort Wayne	Allen
Bishop, Charles A.	South Bend	St. Joseph	*Boyd, N. E.	Freelandville	Knox	Buneh, Rollin H.	Muncie	Delaware-
Bitler, C. C.	New Castle	Henry	Boyd, Stella N.	Evansville	Vanderburgh			Blackford
Blak, Claude S.	Warren	Huntington	Boyd-Snee, Harry (H)	South Bend	St. Joseph	Bundrant, Hersehel	Detroit, Mich.	Allen
Black, Edgar K.	Wabash	Wabash	*Boyer, E. B.	Indianapolis	Marion	*Bundy, Merle	Salem	Washington
*Blackburn, Erwin	South Bend	St. Joseph	Boyer, Floyd A.	Indianapolis	Marion	*Bunge, Clarence E.	Logansport	Cass
Blackford, Florenee	Indianapolis	Marion	Boyer, Grae M.	Marion	Grant	Bunker, L. Z.	N. Manchester	Wabash
Blackford, R. E.	Indianapolis	Marion	Boys, Floyd E.	Indianapolis	Marion	Bureham, J. B.	Gary	Lake
						Burehardt, Louis (H)	Indianapolis	Marion

Name	City	County	Name	City	County	Name	City	County
Burdette, Harold F.	Indianapolis	Marion	*Chambers, L. B.	Union City	Randolph	Condit, David H.	South Bend	St. Joseph
Burge, A. D.	Marion	Grant	Chandler, L. H.	Millersburg	Elkhart	Conger, Elizabeth	Indianapolis	Marion
Burk, James M.	Decatur	Adams	Chapin, J. P.	Orlando, Fla.	Madison	Congleton, G. C.	Terre Haute	Vigo
Burke, H. L.	Bremen	Marshall	Charles, Etta (H)	Anderson	Madison	Conklin, R. L.	Elkhart	Elkhart
*Burkhardt, B. A.	Tipton	Tipton	*Chattin, V. J.	Washington	Daviess-	Conley, John E.	Fort Wayne	Allen
Burkle, J. C.	W. La Fayette	Tippecanoe			Martin	Conley, Joseph L.	Indianapolis	Marion
Burleson, C. E.	La Porte	La Porte	*Chavinson, Benj. F.	Decatur	Adams	Conley, T. M.	Kokomo	Howard
*Burman, Richard G.	Jeffersonville	Clark	Chen, K. K.	Indianapolis	Marion	*Comell, P. S.	Shelbyville	Marshall
*Burnett, A. B.	New Castle	Henry	*Cheney, F. D.	Indianapolis	Marion	Connelly, J. J.	Terre Haute	Vigo
Burns, Elizabeth	Fort Wayne	Allen	Chenoweth, A. C.	Leesburg	Huntington	Conner, D. N.	Markleville	Madison
Burns, Paul E.	Montpelier	Delaware-	Chester, H. R.	Fort Wayne	Allen	Conner, T. E.	Freetown	Jackson
		Blackford	Chevigny, J. J.	Gary	Lake	*Connerley, M. L.	Boston, Mass.	Marion
Burress, B. O.	Washington	Daviess-	Chidlaw, B. W.	Hammond	Lake	Connoy, Andrew F.	Westfield	Hamilton
		Martin	Childs, A. G. W.	Madison	Jefferson	Conover, Earl	Evansville	Vanderburgh
Burris, F. L.	Michigan City	La Porte	*Childs, Wallace E.	Princeton	Gibson	Conrad, E. M.	Anderson	Madison
Burroughs, C. A.	Frankfort	Clinton	Chittick, A. G.	Frankfort	Clinton	Conway, Chester C.	Indianapolis	Marion
Burrous, E. Lee	Peru	Miami	Christophel, Verna	Mishawaka	St. Joseph	Conway, Glenn	Indianapolis	Marion
*Burton, F. H.	Indianapolis	Marion	Christophel, W. B.	Mishawaka	St. Joseph	Cook, C. J. (H)	Indianapolis	Marion
Bush, H. R.	Cannelton	Perry	Clancy, J. F.	Hammond	Lake	*Cook, Charles E.	No. Manchester	Wahash
Bussard, C. F.	South Bend	St. Joseph	Clapp, Fred R.	South Bend	St. Joseph	Cook, E. C.	Madison	Jefferson
Butler, Raymond	Beech Grove	Marion	*Clark, Charles	South Bend	St. Joseph	Cook, G. M.	Hammond	Lake
Butman, W. C.	Hebron	Porter	Clark, C. M.	Oakland City	Gibson	Cooksey, Thomas L.	Crawfordsville	Montgomery
*Butterfield, Robt. M.	Muncie	Delaware-	Clark, C. P.	Indianapolis	Marion	Coomes, M. Joseph	Shelbyville	Shelby
		Blackford	*Clark, Cyrus J.	Indianapolis	Marion	*Cooney, Charles J.	Fort Wayne	Allen
Buttz, Rose J.	Indianapolis	Marion	Clark, Fred O.	Syracuse	Elkhart	Coons, John D.	Lebanon	Boone
Buxton, Eva (H)	Rockport	Spencer	Clark, Ivan A.	Paoli	Orange	*Cooper, George W.	Michigan City	LaPorte
Byers, Norman R.	Bedford	Lawrence	*Clark, L. J.	Indianapolis	Marion	Cooper, H. L.	South Bend	St. Joseph
*Byrne, Basil	New Albany	Floyd	Clark, M. E.	Cambridge City	Wayne-	Cooper, Leo Kenneth	Gary	Lake
				Union		Cooper, Ross A.	Carmel	Hamilton
Cabell, A. L. (H)	Terre Haute	Vigo	Clark, Stanley A.	South Bend	St. Joseph	Cooper, Thomas L.	Logansport	Cass
*Cacia, Jolin J.	Evansville	Vanderburgh	*Clark, Wm. H.	South Bend	St. Joseph	Copeland, C. C. (H)	North Madison	Jefferson
Cahal, E. E.	Indianapolis	Marion	*Clark, W. R.	Fort Wayne	Allen	Copeland, G. W.	Vevay	Switzerland
Cahn, Hugo M.	Indianapolis	Marion	Clarke, Elton R.	Kokomo	Howard	Copeland, S. J.	Indianapolis	Marion
Call, E. B.	Knightstown	Henry	Clauser, A. C.	Delphi	Carroll	Corbin, E. M. (H)	Sullivan	Sullivan
Call, H. F.	Indianapolis	Marion	Clauser, E. H.	Muncie	Delaware-	*Corboy, Philip	Valparaiso	Porter
*Callaghan, W. C.	Greensburg	Decatur			Blackford	Corcoran, A. C.	Indianapolis	Marion
*Callahan, R. H.	East Chicago	Lake	Clawson, J. C.	Richmond	Wayne-	Corcoran, Patrick J. V.	Evansville	Vanderburgh
*Calvert, R. R.	West Lafayette	Tippecanoe			Union	*Cornican, Herbert L.	Elkhart	Elkhart
Calvin, Jessie C.	Fort Wayne	Allen	*Clements, A. F.	Evansville	Vanderburgh	*Cornacchione, M.	Indianapolis	Marion
Cameron, D. F.	Fort Wayne	Allen	*Clevenger, J. H.	Muncie	Delaware-	Cornell, Beaumont S.	Fort Wayne	Adams
*Campagna, E. A.	East Chicago	Lake			Blackford	Cortese, Thomas A.	Indianapolis	Marion
Campbell, J. A.	Indianapolis	Marion	Cline, George	Muncie	Delaware-	*Cotter, E. R.	East Chicago	Lake
Campbell, P. A.	Chicago	Marion			Blackford	Cotter, Thomas F.	East Chicago	Lake
Canaday, C. E.	New Castle	Henry	*Close, W. D.	Indianapolis	Marion	Cottingham, C. E. (H)	Indianapolis	Marion
Canaday, J. W.	Indianapolis	Marion	Clutter, T. J.	Mentone	Kosciusko	Cotton, Perry	Elwood	Madison
*Caplin, Irvin	Indianapolis	Marion	Coble, F. H.	Richmond	Wayne-	Cotton, S. M.	Windfall	Tipton
*Caplin, S. S.	Indianapolis	Marion			Union	Coulson, S. B.	Waldron	Shelby
*Carbone, J. A.	Gary	Lake	Coble, R. R.	Indianapolis	Marion	Coults, P. J.	Tell City	Perry
Carey, W. W.	Fort Wayne	Allen	Cochran, R. B.	Vincennes	Knox	Courtney, T. E. (H)	Indianapolis	Marion
Carl, O. U.	Peru	Miami	Cockrum, Wm. M.	Evansville	Vanderburgh	*Covalt, Donald A.	Muncie	Delaware-
Carlberg, D. L.	Jeffersonville	Clark	Cody, B. L.	Evansville	Vanderburgh			Blackford
Carleton, E. H.	East Chicago	Lake	*Cogswell, H. D.	Whiting	Lake	Covalt, Nila	Muncie	Delaware-
*Carle, Ernest R.	Fort Wayne	Allen	*Cohen, B. B.	East Chicago	Lake			Blackford
*Carlo, J. F.	Hammond	Lake	*Cohen, B. W.	Indianapolis	Marion	*Covell, H. M.	Auburn	De Kalb
Carlson, E. A.	Peru	Miami	*Cohen, Morris	Mitchell	Lawrence	Cox, C. E.	Indianapolis	Marion
*Carlson, Norman R.	Michigan City	La Porte	Cohn, Phillip	New Albany	Floyd	Cox, H. Bailey	Indianapolis	Marion
Carlyle, Ivan E.	Michigantown	Clinton	Cole, A. V.	Hammond	Lake	Cox, Leon T.	Fountain City	Wayne-
Carmichael, C. S.	Seelyville	Vigo	*Cole, Alfred J.	W. Lafayette	Tippecanoe			Union
Carmody, R. F.	Gary	Lake	Cole, Ira	La Fayette	Tippecanoe	*Cox, W. T.	La Fayette	Tippecanoe
Carneal, Thomas E.	Winamac	Pulaski	Cole, R. E.	Muncie	Delaware-	Coyner, A. B.	La Fayette	Tippecanoe
Carney, C. E. (H)	Delphi	Carroll			Blackford	Crabbe, Violet	Wolcott	Tippecanoe
Carney, J. T.	Jeffersonville	Ripley	*Cole, Wm. L.	Evansville	Vanderburgh	Crabtree, L. R.	Columbus	Bartholomew
*Carney, John C.	Monticello	Tippecanoe	*Coleman, H. G.	Odon	Daviess-	Craft, K. L.	Indianapolis	Marion
Carpenter, G. C.	Terre Haute	Vigo			Martin	Craft, William F.	Linton	Greene
Carpenter, J. L.	Alexandria	Madison	Coleman, W. H.	Evansville	Vanderburgh	Craig, R. A.	Kokomo	Howard
Carpentier, Harry F.	Princeton	Marion	Coleman, Wm. S.	Carthage	Rush	Craig, Robert A.	Indianapolis	Marion
*Carrel, Francis E.	Indianapolis	Marion	*Colglazier, Donald	Salem	Washington	*Crain, James W.	St. Meinrad	Spencer
*Carson, Wayne	Indianapolis	Marion	Colglazier, G. G.	Leipsic	Orange	Cramp, Arthur J. (H)	Hendersonville,	
Carter, F. R. Nicholas	South Bend	St. Joseph	*Colip, George	South Bend	St. Joseph		N. C.	Porter
Carter, James C.	Indianapolis	Marion	Collett, G. A.	Crawfordsville	Montgomery	Crampton, C. C.	Delphi	Carroll
*Carter, J. V.	Tipton	Tipton	Collings, T. J.	Rockville	Parke-	Crane, Albert L.	Evansville	Vanderburgh
Carter, L. D.	Indianapolis	Marion			Vermillion	Crawford, Helen	Wausau, Wis.	Marion
Carter, Oren E.	Indianapolis	Marion	Collins, A. W.	Anderson	Madison	Crawford, W. G.	Terre Haute	Vigo
Cartwright, E. L.	Fort Wayne	Allen	Collins, Hubert L.	Indianapolis	Marion	Creel, Donald	Angola	Steuben
Casebeer, P. B.	Clinton	Parke-	Collins, J. N.	Indianapolis	Marion	Crews, C. H.	Hammond	Lake
		Vermillion	Combs, Charles N.	Terre Haute	Vigo	Crimm, Paul D.	Evansville	Vanderburgh
*Caseley, Donald F.	Indianapolis	Marion	*Combs, Herman	Evansville	Vanderburgh	Cring, George	Portland	Jay
Casey, Stanley M.	Huntington	Huntington	Combs, John H.	Evansville	Vanderburgh	*Cripe, E. P.	Redkey	Jay
Casper, Joseph	Jasper	Duhois	*Combs, Nelson B.	Mulberry	Clinton	Crockett, F. S.	La Fayette	Tippecanoe
Casper, J. P.	Jasper	Duhois	Combs, Pearl B.	Evansville	Vanderburgh	Crockett, H. E.	Indianapolis	Marion
Cassady, J. V.	South Bend	St. Joseph	*Combs, Stuart R.	Terre Haute	Vigo	Crossland, Steward H.	Gary	Lake
*Cassidy, John L.	Evansville	Vanderburgh	Comer, Charles W.	Mooreville	Morgan	Crowder, James H.	Sullivan	Sullivan
*Caton, J. R.	South Bend	St. Joseph	Comer, J. E.	Mooreville	Morgan	Crowder, J. R.	Sullivan	Sullivan
Catlett, M. B.	Fort Wayne	Allen	*Comer, Kenneth E.	Mooreville	Morgan	*Crum, Marion M.	Angola	Steuben
Cavins, A. W.	Terre Haute	Vigo	Compton, C. B.	Frankfort	Clinton	*Culbertson, C. S.	South Bend	St. Joseph
Caylor, Harold D.	Bluffton	Wells	Compton, George	Tipton	Tipton	Culbertson, Clyde G.	Indianapolis	Marion
Caylor, Truman E.	Bluffton	Wells	Compton, Silas M.	South Bend	St. Joseph	Cullen, P. K.	Indianapolis	Marion
*Challman, W. B.	Mount Vernon	Posey	*Compton, Walter A.	Elkhart	Elkhart	Cullane, C. W.	Evansville	Vanderburgh
*Chambers, A. R.	Fort Wayne	Allen	*Comstock, Glenn E.	Gary	Lake	Culmer, W. N.	Bloomington	Monroe

Name	City	County	Name	City	County	Name	City	County
Cummings, D. J.	Brownstown	Jackson	Denny, Edgar C.	Richmond	Wayne-Union	Duggan, J. A.	South Bend	St. Joseph
Cunningham, J. M.	Indianapolis	Marion	Denny, Frank T.	Ladoga	Montgomery	Duke, B. E.	Decatur	Adams
Cure, Elmer T.	Muncie	Delaware-Blackford	Denny, Fred C.	Madison	Jefferson	Dukes, F. M.	Dugger	Sullivan
Curry, Claude A.	Terre Haute	Vigo	Denny, J. W.	Indianapolis	Marion	*Dukes, Richard	Dugger	Sullivan
Curtner, M. L.	Vincennes	Knox	*Denton, Larkin D.	Greentown	Howard	Duncan, J. S.	Gary	Lake
*Cushman, J. B.	Gary	Lake	*Denzer, E. K.	Evansville	Vanderburgh	Duncan, Wm. F. (H)	Aurora	Dearborn-Ohio
Custer, E. W.	South Bend	St. Joseph	Denzer, Wm. Oliver	Evansville	Vanderburgh	Dunlap, Harold	Indianapolis	Marion
Cuthbert, F. S.	Kokomo	Howard	Deputy, E. M.	Dugger	Sullivan	Dunn, F. W.	Muncie	Delaware-Blackford
*Cuthbert, M. P.	Kokomo	Howard	*Deputy, Rolland	Indianapolis	Marion	Dunning, L. M.	Indianapolis	Marion
Dahling, C. W.	New Haven	Allen	Derbyshire, John E.	Van Buren	Grant	Dupes, L. E.	Hobart	Lake
Dailey, J. E.	Terre Haute	Vigo	*Derhammer, G. L.	Brookston	Tippecanoe	*Durkee, M. S.	Evansville	Vanderburgh
*Dainko, A. J.	Whiting	Lake	Derian, M. H.	Gary	Lake	*Dusard, Joseph C.	Bedford	Lawrence
Dale, B. C.	Marion	Grant	Dester, Herbert E.	Basna, India	Marion	Dutchess, C. T.	Galveston	Cass
Dale, J. W.	Chesterton	Porter	DeTar, G. B.	Winslow	Pike	Dutton, H. H.	Martinsville	Morgan
Dalton, John E.	Indianapolis	Marion	Detrick, H. W.	Hammond	Lake	DuVall, W. N.	Mishawaka	St. Joseph
Dalton, Naomi	Bloomington	Monroe	*Dettloff, Frederick	Cloverdale	Putnam	*Dyar, E. W., Jr.	Indianapolis	Marion
Dancer, C. R.	Fort Wayne	Allen	*Deutsch, Wm.	Muncie	Delaware-Blackford	*Dyeus, W. A.	Evansville	Vanderburgh
Dando, George H.	Hartford City	Delaware-Blackford	DeWees, Dwight L.	Indianapolis	Marion	*Dyer, G. W.	Terre Haute	Vigo
Daniel, J. C.	Indianapolis	Marion	Dewey, Fred N. (H)	Elkhart	Elkhart	*Dykhuizen, T. A.	Frankfort	Clinton
Danieleski, L. J.	Gary	Lake	Dewey, George W.	Pine Village	Tippecanoe	*Sades, Ralph C.	Valparaiso	Porter
Daniels, E. O.	Marion	Grant	DeWitt, C. H.	Valparaiso	Porter	*Eastman, J. R. Jr.	Indianapolis	Marion
Daniels, G. R.	Marion	Grant	Diamond, Leo	Marion	Grant	*Eaton, E. R.	Indianapolis	Marion
*Daniels, Robert E.	Decatur	Adams	Diamondstein, Jos.	Calumet City, Ill.	Lake	Eaton, L. D.	Princeton	Marion
Danruther, C. B.	La Porte	La Porte	*Dian, A. J.	Gary	Lake	Eaton, M. J.	La Fayette	Tippecanoe
Dare, Lee A.	Jeffersonville	Clark	Dian, Julia G.	Gary	Lake	Eberhart, L. L.	Angola	Steuben
Darling, Dorothy	South Bend	St. Joseph	Kuzmiltz			Eberly, K. C.	Fort Wayne	Allen
Barroch, S. C.	Cayuga	Parke-Vermillion	*Dick, Jack	Huntington	Huntington	Ebert, J. Wayne	Indianapolis	Marion
Daubenheyer, M. F.	Charlestown	Ripley	*Dickens, K. L.	Martinsville	Morgan	Eberwein, J. H.	Indianapolis	Marion
*Daugherty, F. N.	Crawfordsville	Montgomery	*Dickson, D. D.	Letts	Decatur	Eby, Ida L.	Goshen	Elkhart
*Davies, W. L.	Evansville	Vanderburgh	*Dieckman, Herbert S.	Evansville	Vanderburgh	Echternacht, A. P.	Indianapolis	Marion
Davidson, N. Cort	Indianapolis	Marion	Dielman, F. C.	Fulton	Fulton	Eckhart, G. G.	Marion	Grant
*Davidson, Wm. D.	Evansville	Vanderburgh	*Dierolf, E. J.	Gary	Lake	Eddavitch, B. M.	Fort Wayne	Allen
Davidson, W. R.	Evansville	Vanderburgh	Dieter, Wm. J.	Indianapolis	Marion	Edwards, Bernard	South Bend	St. Joseph
Davin, Julia R.	Rockville	Parke-Vermillion	*Dietl, E. L.	South Bend	St. Joseph	Edwards, E. T.	Vincennes	Knox
Davis, Alice H.	Hammond	Lake	Dilley, Fred C.	Brazil	Clay	*Edwards, W. F.	New Albany	Floyd
Davis, Carl M.	Valparaiso	Porter	*Dillinger, George R.	French Lick	Orange	Egan, B. W.	Logansport	Cass
Davis, D. F.	New Albany	Floyd	Dillman, Carl E.	Corydon	Harrison	*Egbert, H. L.	Indianapolis	Marion
Davis, E. C.	Muncie	Delaware-Blackford	Dilts, Robert	Indianapolis	Marion	Egbert, Robert	Martinsville	Morgan
*Davis, George D.	Indianapolis	Marion	*Dingle, Paul	Richmond	Wayne-Union	Egbert, Roy	Indianapolis	Marion
Davis, George H.	Union City	Randolph	Dininger, W. S.	Winchester	Randolph	Eggers, E. L.	Hammond	Lake
Davis, J. A.	Flat Rock	Shelby	*Dittmer, J. E.	Valparaiso	Porter	Eggers, H. W.	Hammond	Lake
Davis, John A.	Indianapolis	Marion	Dittmer, S. E.	Kouts	Porter	Ehrich, W. S.	Evansville	Vanderburgh
*Davis, J. M.	Indianapolis	Marion	*Dittmer, Thomas L.	Kouts	Porter	Ehrman, C. D.	Rockport	Spencer
Davis, John C.	Logansport	Cass	Ditton, I. W.	Fort Wayne	Allen	Eichelberger, W. W.	Evansville	Vanderburgh
Davis, Joseph B.	Philadelphia Pa.	Grant	Dixon, Rex	Anderson	Madison	Eicher, F. I.	Wakarusa	Elkhart
Davis, L. H.	Mentone	Kosciusko	Dobbins, A. O.	Valparaiso	Porter	*Eicher, Palmer	Decatur	Adams
Davis, Marvin R.	Marion	Grant	Dobbins, Thomas	Evansville	Vanderburgh	Eifert, E. E.	Leagootee	Daviss
Davis, Neal	Columbus	Bartholomew	*Dodds, James U.	Hartford City	Delaware-Blackford	*Eikenberry, H. W.	Peru	Miami
*Davis, Parvin M.	New Albany	Floyd	Dodds, Wemple	Crawfordsville	Montgomery	*Eisaman, Jack L.	Bluffton	Wells
Day, C. W.	Indianapolis	Marion	Dollens, Claude	Oolitic	Lawrence	*Eisamen, C. L.	Indianapolis	Marion
Day, George H.	Indianapolis	Marion	Dome, H. S.	Tell City	Perry	Eisenberg, D. A.	Hammond	Lake
Day, John	New Albany	Floyd	Donahue, C. M.	Carmel	Hamilton	Eisenlohr, Eugene	Terre Haute	Vigo
*Day, W. D. C.	Indianapolis	Marion	*Donahue, G. R.	La Fayette	Tippecanoe	Eisterhold, John A.	Evansville	Vanderburgh
Deal, Eleanor H.	Indianapolis	Jackson	Donato, Albert M.	Indianapolis	Marion	Eldridge, Gail E.	Indianapolis	Marion
*Dean, Donald I.	Rushville	Rush	Donchess, J. C.	Gary	Lake	Elledge, Ray	Hammond	Lake
Dean, Michael F.	Indianapolis	Marion	*Donovan, S. J.	Michigan City	La Porte	Elliott, John C.	Guilford	Dearborn-Ohio
Deardorff, O. M.	Muncie	Delaware-Blackford	Dorman, W. L.	Indianapolis	La Porte	Elliott, L. A.	Elkhart	Elkhart
*Dearmin, R. M.	Indianapolis	Marion	*Dorrance, T. O.	Bluffton	Wells	*Elliott, R. A.	Gary	Lake
*DeArmond, Murray	Indianapolis	Marion	Doty, Flavia M.	Traverse City, Mich.	Lake	Elliott, R. H.	Connersville	Fayette-Franklin
Decker, H. B.	Terre Haute	Vigo	Doty, J. R.	Gary	Lake	Ellis, Bert	Indianapolis	Marion
DeDario, L. M.	Elkhart	Elkhart	Douglas, G. R.	Valparaiso	Porter	*Ellis, L. H.	Lebanon	Boone
*Deems, M. B.	Huntington	Huntington	Dowell, E. H.	Rockville	Parke-Vermillion	*Ellis, S. R.	Versailles	Ripley
Deen, H. H.	Leavenworth	Crawford	*Dragoo, Farrol	Middletown	Madison	Ellison, Alfred	South Bend	St. Joseph
Deer, Blau F.	Indianapolis	Marion	*Drake, John C.	Anderson	Madison	Elser, L. W.	Seymour	Jackson
Deever, J. W.	Indianapolis	Marion	Draper, M. H.	Fort Wayne	Allen	Elsten, A. W.	Anderson	Madison
DeFoe, W. A.	Mooreland	Henry	Draper, R. H.	Bremen	Marshall	Elston, L. W.	Fort Wayne	Allen
DeFrees, Henry (H)	Nappanee	Elkhart	Dreyer, Ralph W.	Knightstown	Henry	Elston, Ralph W.	Fort Wayne	Allen
*DeGrazia, E. J.	Valparaiso	Porter	*Drohan, E. P.	Lawrenceburg	Dearborn-Ohio	Emchiser, Donald C.	Hammond	Allen
*DeLawter, Pierre	Indianapolis	Marion	Druley, G. N.	Kokomo	Howard	Emenisher, John L.	Woodburn	Allen
DeLong, C. A.	Gary	Lake	Dubois, C. C.	Warsaw	Kosciusko	*Emery, Charles B.	Bedford	Lawrence
DeLong, O. A. (H)	Elizabethtown	Bartholomew	Dubois, Franklin T.	Liberty	Wayne-Union	Emery, Charles H. (H)	Bedford	Lawrence
De Motte, C. Bowen	Indianapolis	Marion	*Duckworth, James W.	San Francisco, Calif.	Marion	Emhardt, J. W. A.	Indianapolis	Marion
DeMotte, Jerome	Odon	Daviess-Martin	Dudding, J. E.	Hope	Bartholomew	*Emme, R. W.	Harlan	Allen
*DeMotte, R. A.	Bloomington	Monroe	*Duemling, Arnold H.	Fort Wayne	Allen	*Engel, E. L.	Evansville	Vanderburgh
DeNaut, J. F.	Knox	Starke	*Duemling, W. W.	Fort Wayne	Allen	*Engeler, J. E.	Indianapolis	Marion
Denman, R. D.	Helmer	Steuben	Dugan, Thomas J.	Indianapolis	Marion	*Engle, J. M.	Portland	Jay
Denny, Charles W. (H)	North Madison	Jefferson	Dugan, Wm. M.	Indianapolis	Marion	Engle, Russell B.	Farmland	Randolph
						*Englebert, W. F.	Fort Wayne	Allen
						Engleman, H. K.	Georgetown	Floyd
						English, C. H. (H)	Fort Wayne	Allen
						English, H. E.	Rensselaer	Jasper
						English, H. M.	Gary	Newton Lake

Name	City	County	Name	City	County	Name	City	County
English, J. P.	South Bend	St. Joseph	Foreman, W. A.	Brookville	Fayette-Franklin	*Geiger, Dillon	Bloomington	Monroe
Engstrom, Robert B.	Michigan City	LaPorte				Geisel, E. E.	Gary	Lake
Ensminger, L. A.	Indianapolis	Marion	Forry, Frank	Indianapolis	Marion	Geisinger, L. N.	Auburn	De Kalb
Entner, Charles L.	Connersville	Wayne-Union	Forster, N. K.	Hammond	Lake	*Gentile, John P.	New Albany	Floyd
*Episcopo, A. R.	Mitchell	Lawrence	Forsyth, D. H.	Terre Haute	Vigo	*George, Charles L.	Indianapolis	Marion
Epple, S. L.	Bristow	Perry	Fosbrink, E. L.	Syracuse	Elkhart	*Gerding, William J.	Fort Wayne	Allen
*Erdel, Milton W.	Frankfort	Clinton	Fosler, D. W.	Indianapolis	Marion	Gerrish, D. A.	Terre Haute	Vigo
Erehart, A. D.	Anderson	Madison	*Fouts, Joseph R.	English	Crawford	Gerrish, W. D.	Clinton	Parke-Vermillion
Erehart, M. G.	Huntington	Huntington	*Fouts, Paul J.	Indianapolis	Marion			
Ericksen, Lester G.	South Bend	St. Joseph	Fox, C. Philip	Washington	Daviess-Martin	*Gery, Richard E.	La Fayette	Tipppecanoe
Ericsen, H. L.	Windfall	Tipton				Gessler, W. F.	Fort Wayne	Allen
Ernst, H. C. W.	East Chicago	Lake	Fox, F. H.	Hammond	Lake	Gevirtz, M. B.	Hammond	Lake
Erwin, H. G.	Lagrange	Lagrange	Fox, M. S.	Bicknell	Knox	Gibbs, Charles	Greenfield	Hancock
Eshleman, L. H.	Marion	Grant	Fox, R. II.	Bicknell	Knox	Gibbs, E. R.	Wilkinson	Hancock
Estel, G. A.	Madison	Jefferson	Foy, H. W.	Fort Wayne	Allen	Gibbs, Joseph W.	Danville	Hendricks
*Estlick, R. E.	Fort Wayne	Allen	Frank, J. R.	Valparaiso	Porter	Gibson, J. J.	Alexandria	Madison
Evans, R. M.	Russville	Howard	Frank, L. L.	South Bend	St. Joseph	Gick, Herman	Indianapolis	Marion
*Everly, Ralph	Indianapolis	Marion	Franklin, Ernest J.	Indianapolis	Marion	Gifford, F. E.	Indianapolis	Marion
Eviston, J. B.	Huntington	Huntington	Frankowski, Clementine	Whiting	Lake	Gilbert, Ivan	Terre Haute	Vigo
						Gilkison, J. S.	Shoals	Daviess-Martin
Fagaly, A. T.	Lawrenceburg	Dearborn-Ohio	*Frantz, Mount E.	Danville	Hendricks	Gill, B. P.	Mitchell	Lawrence
*Fagaly, W. J.	Lawrenceburg	Dearborn-Ohio	Frash, M. G.	La Fayette	Tipppecanoe	*Gill, D. D.	Greenfield	Hancock
			Frash, De Von W.	South Bend	St. Joseph	Gillespie, C. E.	Seymour	Jackson
Fair, H. D. (H)	Muncie	Delaware-Blackford	Freed, James C.	Attica	Fountain-Warren	*Gillespie, C. F.	Indianapolis	Marion
						Gillespie, G. R.	Brownstown	Jackson
Faltin, Ladislaus	South Bend	St. Joseph	Freed, J. E.	Terre Haute	Vigo	*Gillespie, J. E.	Indianapolis	Marion
Farabee, Charles R.	North Judson	Stark	Freeman, F. M.	Goshen	Elkhart	Gillespie, J. F. (H)	Greencastle	Putnam
Fargher, F. M.	Michigan City	La Porte	Freireich, Kal	South Bend	St. Joseph	*Gilliatt, J. P.	Salem	Washington
Fargher, R. A.	La Porte	La Porte	French, Virgil	Riley	Vigo	*Gilliam, Luther A.	Indianapolis	Marion
Farnham, W. C.	South Bend	St. Joseph	French, Wm. G.	Evansville	Vanderburgh	Gillum, John R.	Terre Haute	Vigo
Farnsworth, Samuel A.	La Porte	La Porte	Friedrich, L. M.	Hobart	Lake	Gilman, M. M.	South Bend	St. Joseph
*Farrell, J. T.	Indianapolis	Marion	Frith, Gladys D.	South Bend	St. Joseph	Gilmore, L. L.	Vincennes	Knox
Farver, M. A.	Middlebury	Elkhart	Frith, Louis G.	South Bend	St. Joseph	Gilmore, R. A.	Michigan City	La Porte
Fattie, John B. (H)	Anderson	Madison	Fritsch, L. E.	Evansville	Vanderburgh	Gingerick, C. M.	Liberty Center	Wells
*Faul, Henry J.	Evansville	Vanderburgh	*Fromhold, Willis A.	Indianapolis	Marion	Giordano, A. S.	South Bend	St. Joseph
*Fausset, C. Basil	Indianapolis	Marion	Frost, Thomas T.	Taylorsville, Ill.	Marion	Giorgi, Antonio (H)	Gary	Lake
Feerer, Donald J.	Michigan City	La Porte	*Fry, Robert D.	Indianapolis	Marion	Gipe, W. W.	Tucson, Ariz.	Howard
*Fender, A. H.	Worthington	Greene	Frybarger, S. S.	Converse	Miami	*Gitlin, Max M.	Bluffton	Wells
*Ferguson, A. N.	Fort Wayne	Allen	*Fuelling, James L.	Newburgh	Warrick	*Gitlin, Wm. A.	Bluffton	Wells
Ferguson, C. E. (H)	Indianapolis	Marion	*Fullerton, R. L.	Indianapolis	Marion	Glackman, J. C., Sr.	Rockport	Spencer
*Ferguson, Wm. B.	Indianapolis	Marion	Funk, V. A.	Vincennes	Knox	*Glackman, J. C., Jr.,	Rockport	Spencer
Ferrara, Donald W.	Peru	Miami	Funkbouser, A. G.	Indianapolis	Marion	*Gladstone, N. H.	Fort Wayne	Allen
Ferrara, S. J.	Peru	Miami	Funkbouser, Elmer	Indianapolis	Marion	Glaser, E. M.	Brookville	Fayette-Franklin
*Ferree, John W.	Indianapolis	Marion	Furgason, Paul C.	Indianapolis	Marion			
Ferrell, Jesse E.	Fortville	Hancock	Furniss, S. A.	Indianapolis	Marion	Glaser, R. E.	Brookville	Fayette-Franklin
*Ferrell, Mars B.	Fortville	Hancock	*Fuson, W. J.	Greencastle	Putnam			
*Ferry, John L.	Whiting	Lake	Fyfe, M. B.	Valparaiso	Porter	Glass, R. L.	Indianapolis	Marion
Ferry, P. W.	Kokomo	Howard				Glendening, J. L.	Indianapolis	Marion
Fessler, G. S.	Rising Sun	Dearborn-Ohio	Gabe, Harry E. (H)	Indianapolis	Marion	Glenn, Fred C.	Tell City	Perry
			Gabe, Wm. E.	Indianapolis	Marion	Glenn, L. F.	Ramsey	Harrison
Fichman, A. M.	Fort Wayne	Allen	Gabbart, J. H.	Elberfeld	Warrick	Glick, O. E.	Kentland	Jasper-Newton
*Fickas, Dallas	Evansville	Vanderburgh	Gable, H. B.	Monticello	White			
Field, W. H.	Evansville	Vanderburgh	Gaddy, Euclid T.	Indianapolis	Marion	Glock, H. E.	Fort Wayne	Allen
Filipek, W. J.	South Bend	St. Joseph	Galbreath, R. S.	Huntington	Huntington	*Glock, M. E.	Fort Wayne	Allen
Fipp, August L.	Rome City	Noble	Galbreth, J. P.	Burnettsville	White	*Glock, Wayne R.	Fort Wayne	Allen
*Firestein, Ben	South Bend	St. Joseph	Gallup, Palmer R.	Michigan City	La Porte	Gobbel, N. E.	English	Crawford
Fish, C. M.	South Bend	St. Joseph	*Gambill, Wm. D.	Indianapolis	Marion	Goethals, Charles J.	Mishawaka	St. Joseph
Fish, Edson C.	South Bend	St. Joseph	Gannon, G. W.	Gary	Lake	Goldstone, Adolph	Gary	Lake
Fisher, Albert	North Judson	La Porte	Gannon, Richard	Gary	Lake	Goldstone, Joseph	Gary	Lake
Fisher, C. N.	La Porte	La Porte	Gante, H. W.	Anderson	Madison	Goldthwaite, H. R.	Marion	Grant
*Fisher, Henry	Marion	Grant	*Ganz, Max	Marion	Grant	*Good, R. P.	Kokomo	Howard
*Fisher, John E.	Clarksburg	Decatur	Garber, E. C.	Dunkirk	Jay	*Goodman, H. T.	Terre Haute	Vigo
*Fisher, K. B.	Indianapolis	St. Joseph	*Garber, J. Neill	Indianapolis	Marion	Goodrich, Albert	New York	Monroe
Fisher, Lawrence F.	South Bend	St. Joseph	Garber, Paul A.	South Whitley	Whitley	Goodwin, C. B. (H)	Kendallville	Noble
Fisher, Pierre J.	Marion	Grant	Garceau, George J.	Indianapolis	Marion	Goodwin, Caroline M.	Indianapolis	Marion
Fisher, Walter S.	Columbus	Bartholomew	*Gardner, Buckman	Indianapolis	Marion	Goodwin, L. D.	Winslow	Pike
Fisk, Frank B.	Indianapolis	Marion	Gardner, M. D.	Michigan City	La Porte	Gozaczewski, Thaddeus	South Bend	St. Joseph
*Fitzgerald, Brice E.	Logansport	Marion	*Gardner, R. A.	Michigan City	La Porte	Gordin, Stanley	Connersville	Fayette-Franklin
Fitzpatrick, H. W.	Elwood	Madison	*Garfield, M. D.	Hobart	Lake			
*Fitzsimmons, E. L.	Evansville	Vanderburgh	Garland, Edgar A.	Evansville	Vanderburgh	Gordin, Stanton E.	Connersville	Fayette-Franklin
*Flack, Russell A.	La Fayette	Tipppecanoe	*Garling, L. C.	Muncie	Delaware-Blackford			
Flanagan, E. P.	Walton	Cass	Garner, H. A.	Hanna	La Porte	Gordon, J. L.	Wheeler	Porter
Flannigan, H. F.	Lagrange	Lagrange	Garner, William	Indianapolis	Marion	Gordon, J. M.	South Bend	St. Joseph
Flanigan, M. B.	Frankton	Madison	*Garner, W. Stanley	Indianapolis	Marion	Goss, Anna	Madison	Jefferson
*Flectwood, R. A.	Nappanee	Elkhart	*Garner, Wm. H.	New Albany	Floyd	Goss, H. W.	Indianapolis	Marion
Fleischer, J. C.	East Chicago	Lake	Garrett, John D.	Indianapolis	Marion	Gould, L. K.	Fort Wayne	Allen
Fleming, C. F.	Elkhart	Elkhart	Garrettson, J. A.	Indianapolis	Marion	Goverchin, Alex	East Chicago	Lake
*Fleming, Justus M.	Elkhart	Elkhart	Garrison, Leon J.	Gas City	Grant	Gracy, Alice	South Bend	St. Joseph
Fletcher, Charles F.	Sumner	Dearborn-Ohio	Garshwiler, W. P.	Indianapolis	Marion	Grassle, Harold P.	Seymour	Jackson
			Garton, H. W.	Fort Wayne	Allen	Graham, A. B.	El Paso, Tex.	Marion
*Flick, John J.	Indianapolis	Marion	Gastineau, F. M.	Indianapolis	Marion	Graham, Cova R.	Bourbon	Marshall
*Flora, Joseph O.	Indianapolis	Marion	Gatch, W. D.	Indianapolis	Marion	*Graham, Thomas	La Fayette	Tipppecanoe
*Folck, J. K.	Princeton	Gibson	*Gates, George E.	South Bend	St. Joseph	Gramling, J. J.	Indianapolis	Marion
*Folkening, N. C.	Detroit, Mich.	Marion	Gaunt, Everett W.	Alexandria	Madison	*Grandstaff, F. L.	Decatur	Adams
Foltz, Lloyd E.	Brownsburg	Hendricks	Gauss, Julius H. P.	Indianapolis	Marion	*Graves, J. W.	Indianapolis	Marion
Folz, C. J.	Evansville	Vanderburgh	*Gehres, R. W.	Shelbyville	Shelby	Graves, Orville M.	Princeton	Gibson
Foreman, Harry L.	Indianapolis	Marion	*Gelder, Roy A.	Indianapolis	Marion	Gray, D. E.	Crown Point	Lake
						Gray, Leon	Martinsville	Morgan

Name	City	County	Name	City	County	Name	City	County
Gray, Paul M.	Huntington	Huntington	*Hammond, Stanley M.	Portland	Jay	*Hedde, E. L.	Logansport	Cass
Grayston, F. W.	Huntington	Huntington	*Hancock, John G.	Indianapolis	Marion	*Hedgecock, R. A.	Frankfort	Clinton
Grayston, Wallace S.	Huntington	Huntington	*Hane, R. L.	Port Wayne	Allen	Hedrick, R. M.	Gary	Lake
Green, F. H., Jr.	Rushville	Rush	Hanna, T. A.	Indianapolis	Marion	Hefti, Karl	Evansville	Vanderburgh
*Green, George F.	South Bend	St. Joseph	*Hannebaum, O. P.	Indianapolis	Marion	Heilman, W. C.	New Castle	Henry
Green, John H.	North Vernon	Jennings	*Hansell, R. M.	Indianapolis	Marion	Heinrichs, H. H.	Indianapolis	Marion
Green, Lowell M.	Rushville	Rush	Hansen, A. H.	Hammond	Lake	*Held, Albert H.	Huntingburg	Dubois
Green, Myron H.	Indianapolis	Marion	Harcourt, A. K.	Indianapolis	Marion	*Held, George A.	Jasper	Dubois
Green, Wm. L.	Pekin	Washington	*Hardesty, K. C.	Fort Wayne	Allen	Heller, N. L.	Dunkirk	Jay
Greene, Claude D.	Spencer	Owen	Hardin, W. E.	Ossian	Wells	Heller, Oscar	Greenfield	Hancock
Greene, F. G.	Bloomington	Parke-Vermillion	Harding, M. Richard	Indianapolis	Marion	Helm, Karl G.	Shoals	Daviess-Martin
*Greer, O. W.	Indianapolis	Marion	Harding, Myron S.	Indianapolis	Marion	Helmen, H. W.	South Bend	St. Joseph
*Gregg, Albert F.	Connersville	Fayette-Franklin	Hardwick, R. S.	East Chicago	Lake	*Helper, Morton	Evansville	Vanderburgh
Greist, H. W. (H)	Monticello	White	Hardy, Charles F.	Kendallville	Noble	Henderson, Arvin	Ridgeville	Randolph
*Greist, John	Indianapolis	Marion	Hardy, John J.	North Liberty	St. Joseph	*Henderson, R. A.	Muncie	Delaware-Blackford
Griest, O. E.	La Fayette	Tippecanoe	Hare, E. H.	Indianapolis	Marion	Hendricks, John D.	Indianapolis	Marion
Griffin, J. P.	Chesterton	LaPorte	Hare, John H.	Evansville	Vanderburgh	Hendricks, John W.	Indianapolis	Marion
Griffis, V. C.	Richmond	Wayne-Union	Hargis, W. T. (H)	Tell City	Perry	Henley, Glenn	Fairmount	Grant
Griffith, J. B.	Crawfordsville	Montgomery	Harkcom, H. E.	St. Paul	Decatur	*Henry, Russell S.	Indianapolis	Marion
*Griffith, James W.	Sheridan	Hamilton	Harkness, R. G.	Terre Haute	Vigo	Henning, Carl	Hanover	Jefferson
Griffith, R. E.	Indianapolis	Marion	*Harmon, C. J.	Richmond	Wayne-Union	Hepburn, C. K.	Indianapolis	Marion
*Grillo, Donald	South Bend	St. Joseph	Harmon, Gladys H.	Richmond	Wayne-Union	Hepner, H. S.	Bloomington	Monroe
Grimes, J. H.	Danville	Hendricks	Harmon, Vachelle E.	South Bend	St. Joseph	*Herbst, R. R.	Hammond	Lake
*Griswold, W. R.	Indianapolis	Marion	Harmon, Wayne	Lynn	Randolph	Herd, Cloyd R.	Peru	Miami
Groman, H. C.	Hammond	Lake	Harold, A. H.	Indianapolis	Marion	*Herendeen, E. V.	Rochester	Fulton
*Gros, Hubert	Delpi	Carroll	Harold, N. E.	Indianapolis	Marion	*Hertler, Jules	Columbia City	Whitley
*Gross, M. E.	Ladoga	Montgomery	Harris, B. W.	Gary	Lake	Herr, John W.	Mount Vernon	Posey
Grossman, W. L.	North Vernon	Jennings	Harris, Carl B.	Indianapolis	Marion	*Herrick, C. L.	Akron	Fulton
Grossnickle, Geo. W.	Elkhart	Elkhart	*Harris, L. E.	La Fayette	Tippecanoe	Herring, G. N.	Piercetown	Kosciusko
*Grosso, W. G.	East Chicago	Lake	Harris, Paul N.	Indianapolis	Marion	*Herrold, G. W.	La Fayette	Tippecanoe
Grove, E. G.	Shelbyville	Shelby	Harris, R. F.	Noblesville	Hamilton	Herschleder, Maxwell	Gary	Lake
*Grzesk, Leo L.	Mishawaka	St. Joseph	Harris, W. L.	Evansville	Vanderburgh	Hershey, E. A.	Churubusco	Whitley
Gudenkauf, Elton B.	Jeffersonville	Clark	*Harrison, B. L.	New Castle	Henry	Hervey, Samuel W. (H)	Fortville	Hancock
*Guild, C. J.	Garrett	De Kalb	Harrison, Wm. H. (H)	Kokomo	Howard	Herzer, C. C.	Evansville	Vanderburgh
Gustafson, G. W.	Indianapolis	Marion	Harshman, L. P.	Fort Wayne	Allen	Hetherington, A. M.	Indianapolis	Marion
Gutellus, C. B.	Indianapolis	Marion	*Harshman, Martin L.	Colfax	Clinton	Heubi, John E.	Indianapolis	Marion
Guthrie, F. C.	Anderson	Madison	*Harstad, C.	Rockville	Parke-Vermillion	Hewins, Warren W.	Evansville	Vanderburgh
Gutierrez, F. A.	Gary	Lake	*Hart, L. Paul	Evansville	Vanderburgh	*Hewitt, M. I.	South Bend	St. Joseph
Gutstein, Richard R.	Kendallville	Noble	Hart, Robert B.	Columbus	Bartholomew	*Hewlett, Thomas H.	New Albany	Floyd
Gwaltney, L. F.	Roadside	Putnam	*Hart, Wm. D.	Anderson	Madison	*Hiatt, R. L.	Richmond	Wayne-Union
Gwin, M. D.	Rensselaer	Jasper-Newton	Hartley, C. A., Jr.	Evansville	Vanderburgh	*Hibner, Nolan A.	Indianapolis	Marion
Habegger, Myron L.	Berne	Adams	Hartley, C. A.	Evansville	Vanderburgh	*Hickman, W. R.	Logansport	Cass
Habermel, John F.	New Albany	Floyd	Hartley, C. A.	Evansville	Vanderburgh	Hickman, Walter	Indianapolis	Marion
Haibich, Carl H.	Indianapolis	Marion	*Hartz, F. Minton	Evansville	Vanderburgh	Hicks, H. S.	Hammond	Lake
Haek, E. C.	Hammond	Lake	*Harvey, B. J.	La Fayette	Tippecanoe	*Hicks, James M.	Huntington	Huntington
Hadden, Claude E.	Indianapolis	Marion	Harvey, Harry C.	Fort Wayne	Allen	Hiestand, H. B.	Philadelphia, Pa.	Marion
Hade, Frederick L.	Bridgeport	Marion	Harvey, R. J.	Whitestown	Boone	Hiestand, H. J.	Pennville	Jay
Hadley, A. W.	La Fayette	Tippecanoe	Harvey, Verne K.	Washington, D. C.		Higbee, Paul	Sullivan	Sullivan
*Hadley, David	Indianapolis	Marion	*Hasewinkle, A. M.	Fort Wayne	Allen	Higgins, George K.	New York City	St. Joseph
Hadley, Harvey	Richmond	Wayne-Union	*Hash, John S.	Indianapolis	Marion	Higgins, O. C.	Lebanon	Boone
Hadley, Murray N.	Indianapolis	Marion	*Haslem, Ezra R.	Terre Haute	Vigo	Hilbert, John W.	South Bend	St. Joseph
*Haffner, H. G.	Fort Wayne	Allen	*Haslem, John R.	Terre Haute	Vigo	Hildebrand, W. O.	Topeka	Lagrange
*Haggard, E. B.	Indianapolis	Marion	Hassinger, C. J.	Indianapolis	Marion	Hill, H. D.	Richmond	Wayne-Union
*Haggard, Gordon H.	Hope	Bartholomew	Hassenmiller, Mart	West Baden	Orange	*Hill, H. E.	Muncie	Delaware-Blackford
Hagie, F. E.	Richmond	Wayne-Union	Hatfield, B. F.	Indianapolis	Marion	*Hill, Paul G.	Cambridge City	Wayne-Union
Hahn, E. V.	Indianapolis	Marion	*Hatfield, N. W.	Indianapolis	Marion	*Hill, Robert	Muncie	Delaware-Blackford
Haley, Paul E.	South Bend	St. Joseph	Hatfield, S. J.	Indianapolis	Marion	Hill, T. N.	Scottsburg	Scott
*Hall, E. H.	Dunkirk	Delaware-Blackford	Hathaway, Clayton B.	Butler	De Kalb	*Hildrup, Don G.	Indianapolis	Marion
*Hall, Frank M.	La Fayette	Tippecanoe	*Hattendorf, A. P.	Fort Wayne	Allen	*Hillery, J. L.	Silver Lake	Kosciusko
*Hall, O. A.	Muncie	Delaware-Blackford	Haus, A. P.	New Albany	Floyd	Hillis, L. J.	Logansport	Cass
Hall, T. C.	Medaryville	Pulaski	Havens, Edward D.	Cicero	Hamilton	*Hillman, Marion W.	South Bend	St. Joseph
Hall, Walter A.	New Albany	Floyd	Havens, Oscar	Cicero	Hamilton	Hillman, W. H.	South Bend	St. Joseph
*Hallam, F. T.	Indianapolis	Marion	*Havice, Jay F.	Fort Wayne	Allen	*Himebaugh, Gilbert	Indianapolis	Marion
*Halleck, H. J.	Winamac	Pulaski	Hawes, J. K.	Columbus	Bartholomew	Himler, James M.	Indianapolis	Marion
Haller, Thomas C.	Williamsport	Fountain-Warren	*Hawes, M. E.	Hartsville	Bartholomew	Hinehman, C. P.	Geneva	Adams
Hamer, H. G.	Indianapolis	Marion	*Hawk, Edgar A.	New Palestine	Hancock	Hine, Ullis B.	Indianapolis	Marion
Hamilton, Alexander	Frankfort	Clinton	*Hawk, James H.	Indianapolis	Marion	Hines, A. V.	Auburn	De Kalb
Hamilton, Allen	La Jolla, Calif.	Allen	Hawkins, Z. T. (H)	Fairmount	Grant	Hines, D. M.	Auburn	De Kalb
Hamilton, Antha A.	Shelburn	Sullivan	*Hayes, J. J.	Fort Wayne	Allen	Hines, Don C.	Indianapolis	Marion
Hamilton, E. E.	Dayton	Tippecanoe	Hayes, T. R.	Muncie	Delaware-Blackford	Hinkson, George D.	Gary	Lake
Hamilton, Guy W.	Washington, D. C.	Jefferson	*Hays, E. L.	Indianapolis	Marion	*Hippensteel, R. R.	Indianapolis	Marion
Hamilton, H. B.	Terre Haute	Vigo	Hays, George R.	Richmond	Wayne-Union	*Hippensteel, R. O.	Fremont	Stauben
Hamilton, J. R.	Mitchell	Lawrence	Hazel, James T.	Freedom	Owen	Hirshel, L. W.	Batesville	Ripley
Hamilton, M. Luther	Newberry	Greene	Hazinski, R. T.	Griffith	Lake	Hochhalter, Marian	Logansport	Cass
Hamilton, O. G.	Bluffton	Wells	*Headley, L. M.	Lebanon	Boone	Hodges, Fletcher	Indianapolis	Marion
Hamilton, R. C.	East Chicago	Lake	Heald, Walter	West Lebanon	Fountain-Warren	Hodges, Wm. A.	Oaktown	Knox
*Hammersley, Geo. K.	Frankfort	Clinton	Healy, Wm. F.	Evansville	Vanderburgh	*Hodgin, Philip	Rockville	Parke-Vermillion
*Hammond, Keith	Paoli	Orange	Heard, Albert	Evansville	Vanderburgh	Hoefer, H. R.	Brookville	Fayette-Franklin
			Hearn, Roberts A.	Evansville	Vanderburgh	Hoetzer, Ruth M.	Fort Wayne	Allen
			*Heasty, Robert G.	Michigan City	LaPorte			
			Heberer, J. M.	Evansville	Vanderburgh			
			*Heck, M. C.	Jasper	Dubois			

Name	City	County	Name	City	County	Name	City	County
Hofferkamp, A. G.	New Albany	Floyd	Hutchinson, B. M.	Mishawaka	St. Joseph	*Kahan, H. L.	Gary	Lake
*Hoffman, A. F.	Fort Wayne	Allen	*Hutto, W. H.	Kokomo	Howard	*Kahler, M. V.	Indianapolis	Marion
Hoffman, Curtis R.	Richmond	Wayne-	Hyde, Carroll	South Bend	St. Joseph	*Kalb, Everett L.	Indianapolis	Marion
		Union	*Hyman, Bernard	Indianapolis	Marion	Kamm, Bernard A.	South Bend	St. Joseph
Hoffman, Doris	Vincennes	Knox	*Hynes, Roy	Indianapolis	Marion	Kamman, G. H.	Seymour	Jackson
Hoffman, R. V.	South Bend	St. Joseph				Kammian, H. H.	Columbus	Bartholomew
Hofmann, Andrew	Hammond	Lake	Iddings, J. W.	Crown Point	Lake	*Kammen, Leo	Indianapolis	Marion
Hofmann, J. Wm.	Indianapolis	Marion	*Ikms, R. G.	La Fayette	Tipppecanoe	Kammer, Adolph G.	Oakridge,	Lake
Hofmann, S. P.	Fort Wayne	Allen	*Ingalls, Clair	Washington	Daviess-		Tenn.	
Holdeman, Lillian	South Bend	St. Joseph			Martin	Kantzer, Floyd B.	Garrett	DeKalb
*Holdeman, R. W.	South Bend	St. Joseph	Ingwell, Guy B.	Knox	LaPorte	Karsell, W. A.	Bloomington	Marion
Holladay, L. J.	La Fayette	Tipppecanoe	Inlow, C. Fred	Shelbyville	Shelby	Katterjohn, James C.	Indianapolis	Marion
*Holland, Chas. E.	Bloomington	Monroe	*Inlow, Herbert	Shelbyville	Shelby	Kauffman, H. M.	Evansville	Vanderburgh
Holland, E. E.	Richmond	Wayne-	Inlow, W. D.	Shelbyville	Shelby	*Kaufman, Sidney A.	Indianapolis	Marion
		Union	Irey, P. R.	Plymouth	Marshall	Kay, Oran	Spencer	Owen
Holland, D. J.	Bloomington	Monroe	Irwin, Seth	Summitville	Madison	*Keefe, Thomas L.	Logansport	Cass
*Holland, Philip	Bloomington	Monroe	Ish, E. A.	Waterloo	De Kalb	*Keeling, F. E.	Portland	Jay
Holliday, L. D.	Fairmont	Grant	*Iske, Paul G.	Indianapolis	Marion	Keeling, J. E. (H)	Waldron	Shelby
Hollingsworth, A. A.	Indianapolis	Marion	*Isler, N. C.	Jeffersonville	Clark	Keenan, R. L.	Indianapolis	Marion
Hollingsworth,	Princeton	Gibson	*Iterman, G. E.	New Castle	Henry	Keene, T. V.	Indianapolis	Marion
			Ives, R. J.	Francesville	Pulaski	Keever, C. H.	Indianapolis	Marion
Marshall P. (H)						Keiser, V. D.	Indianapolis	Marion
*Hollingsworth, Maurice	Beech Grove	Marion	*Jackman, Abraham I.	Hammond	Lake	Keith, F. E.	Richmond	Wayne-
Holloway, W. A.	Logansport	Cass	Jackson, F. E.	Indianapolis	Marion			Union
Holman, J. E.	Indianapolis	Marion	*Jackson, J. K.	Aurora	Dearborn-	Keller, F. G. (H)	Alexandria	Madison
*Holman, J. E. Jr.	Indianapolis	Marion			Ohio	*Kelly, Don E.	Indianapolis	Marion
Holmes, Claude D.	Frankfort	Marion	Jackson, J. L.	Indianapolis	Marion	Kelly, F. H.	Argos	Marshall
*Holmes, G. W.	Crown Point	Lake	Jackson, J. M.	Aurora	Dearborn-	Kelly, J. F.	Indianapolis	Marion
*Holmes, W. W.	Logansport	Cass			Ohio	Kelly, J. N.	La Porte	La Porte
Holsinger, R. E.	Fort Wayne	Allen	Jackson, J. W.	Indianapolis	Marion	*Kelly, W. C.	Indianapolis	Marion
Hooke, Sam W.	Noblesville	Hamilton	Jacobs, H. A.	Indianapolis	Marion	Kelly, W. R.	Goshen	Elkhart
Hoopes, Jane	Evansville	Vanderburgh	*Jacobs, L. G.	Indianapolis	Marion	Kelly, Walter F.	Indianapolis	Marion
Hoover, D. A.	Terre Haute	Vigo	Jaeger, A. S.	Indianapolis	Marion	Kelsey, A. J.	Monterey	Pulaski
Hoover, J. J.	Terre Haute	Vigo	James, N. A.	Tell City	Perry	Kelsey, L. E.	Kewanna	Fulton
*Hoover, Peter B.	Boonville	Warrick	Jaquith, O. S.	Indianapolis	Marion	Kelsey, Robert M.	La Porte	La Porte
Hopkins, Lester H.	Batesville	Ripley	*Jay, Arthur N.	Indianapolis	Marion	*Kemp, John T.	Michigan City	La Porte
*Hoppenrath, W. M.	Elwood	Madison	Jeffries, K. I.	Indianapolis	Marion	*Kemp, W. A.	Connersville	Fayette-
Hoppenrath, Wm. H.	Elwood	Madison	Jenkins, J. M. (H)	Cortland	Jackson			Franklin
*Hord, L. J.	Shelbyville	Shelby	*Jenkinson, W. E.	Mount Vernon	Posey	Kemper, A. T.	Muncie	Delaware
Hornaday, W. A.	Hammond	Lake	Jennings, Frank	Oaklandon	Marion	Kemp, G. F.	Indianapolis	Marion
Horswell, R. G.	Bristol	Elkhart	Jermstad, Robert J.	Fort Wayne	Allen	*Kendall, F. M.	Alexandria	Madison
Horton, Joseph E.	Flint, Mich.	Benton	Jerome, J. N.	Evansville	Vanderburgh	*Kendrick, Frank J.	Gary	Lake
*Horton, Robert	Indianapolis	Marion	Jewell, Earl B.	Logansport	Cass	*Kendrick, W. M.	Indianapolis	Marion
Hostetler, Carl M.	Goshen	Elkhart	Jewett, L. E.	Wabash	Wabash	Kennedy, Eva	Camden	Carroll
House, J. W.	Bruceville	Knox	Indianapolis	Indianapolis	Wabash	*Kennedy, H. F.	Indianapolis	Marion
Houser, A. D.	LaPorte	St. Joseph	Jinks, C. H.	Indianapolis	Marion	Kennedy, R. O.	Rushville	Rush
Houser, Wayne W.	Monon	Tipppecanoe	Jimmings, Loren E.	Garrett	DeKalb	Kennedy, Samuel (H)	Shelbyville	Shelby
How, John T.	Lakeville	St. Joseph	*Jobes, James E.	Indianapolis	Marion	Kennedy, W. U.	New Castle	Henry
How, Louis E.	Lakeville	St. Joseph	Jobes, N. E.	Indianapolis	Marion	Kennington, D. J.	Michigan City	La Porte
Howard, W. H.	Hammond	Lake	Johns, D. R.	East Chicago	Lake	Kent, J. A.	Mulberry	Clinton
*Howell, R. D.	Indianapolis	Marion	Johns, Elmer D.	Zionsville	Boone	*Kenyon, C. E.	Cambridge City	Wayne-
Hoyt, Lester H.	Indianapolis	Marion	Johnson, C. E.	Rensselaer	Jasper-			Union
Huber, Carl P.	Indianapolis	Marion			Newton	Kepler, R. W.	La Porte	La Porte
Huckleberry, Irvin	Salem	Washington	Johnson, E. N.	Sandborn	Knox	Kercheval, C. F.	Clinton	Parke-
Hudson, Foster J.	Indianapolis	Marion	Johnson, Earl E.	Covington	Fountain-			Vermillion
Huff, A. D.	Marion	Grant			Warren	Kercheval, J. M.	Clinton	Parke-
Huffman, A. D.	South Bend	St. Joseph	Johnson, F. D.	Waynetown	Montgomery			Vermillion
Huffman, V. P.	South Whitley	Whitley	Johnson, G. C.	Evansville	Vanderburgh	Kern, C. B.	Muncie	Delaware-
Hufnagel, C. J.	Richmond	Wayne-	Johnson, J. J.	Milltown	Crawford			Blackford
		Union	Johnson, M. H. C.	Vincennes	Knox	*Kern, C. G.	Lebanon	Boone
Huggins, Victor S.	Evansville	Vanderburgh	Johnson, Paul S.	Richmond	Wayne-	Kerr, A. R.	Attica	Fountain-
Hughes, J. E.	Indianapolis	Marion			Union			Warren
Hughes, L. M.	Paragon	Morgan	*Johnson, R. B.	Butlerville	Jennings	Kerr, Harry R.	Indianapolis	Marion
Hughes, W. F.	Indianapolis	Marion	*Johnson, S. L.	Evansville	Vanderburgh	Kerrigan, J. J. (H)	Michigan City	La Porte
Hull, A. W.	Elkhart	Elkhart	*Johnson, Thomas W.	Indianapolis	Marion	Kerrigan, R. L.	Michigan City	La Porte
Hull, King L.	Bloomfield	Greene	*Johnson, W. A.	Perrysville	Parke-	*Keser, N. E.	Gary	Lake
Hulsman, L. F.	Shelbyville	Shelby			Vermillion	Ketcham, Jane M.	Indianapolis	Marion
*Humphreys, John W.	Darlington	Montgomery	*Johnson, W. H.	Corydon	Madison	Ketcham, John S.	Rossville	Clinton
Hunn, M. F.	Elkhart	Elkhart	Johnson, Wm. F.	Indianapolis	Marion	Kidd, James G.	Roann	Wabash
Hunt, Edgar J.	Terre Haute	Vigo	*Johnston, D. D.	Fort Wayne	Allen	Kidder, J. J.	Salamonia	Jay
*Hunt, Gayle J.	Richmond	Wayne-	Johnston, R. G.	Huntington	Huntington	*Kidder, Orva T.	Fort Wayne	Allen
		Union	Jolly, W. P.	Richland	Spencer	*Kilgore, Byron	Danville	Hendricks
Hunt, George	Richmond	Wayne-Union	Jones, Albert T.	Pendleton	Madison	Kilgore, F. T.	Yorktown	Delaware-
Hunt, Lee	Anderson	Madison	Jones, Clifford M.	Whiting	Lake			Blackford
Hunt, W. B. (H)	Terre Haute	Vigo	Jones, D. D.	Berne	Adams	Killough, Aimee R.	Michigan City	La Porte
Hunter, F. P.	La Fayette	Tipppecanoe	Jones, David E.	Indianapolis	Marion	*Kilmer, John H.	Fort Wayne	Allen
Hunter, Lowell G.	Milan	Ripley	Jones, E. S.	Hammond	Lake	Kim, Young D.	Beech Grove	Marion
Huoni, J. S.	Jeffersonville	Clark	*Jones, Francis P.	Indianapolis	Marion	Kimball, Glen D.	Marion	Grant
Hupe, Charles (H)	La Fayette	Tipppecanoe	Jones, George	Wanamaker	Marion	Kime, Charles E.	Indianapolis	Marion
Hurley, Anson	Muncie	Delaware-	Jones, H. E.	Anderson	Madison	Kime, E. N.	Bloomington	Marion
		Blackford	*Jones, Paul A.	Lyons	Greene	Kime, J. T. (H)	Petersburg	Pike
*Hurley, John R.	Daleville	Delaware-	Jones, R. B.	La Porte	La Porte	*Kimmich, John M.	Kokomo	Howard
		Blackford	Jones, Rilus E.	Clayton	Hendricks	Kindell, H. D.	New Richmond	Montgomery
Hursey, Virgil G.	Milford	Kosciusko	Jones, W. W.	Frankfort	Clinton	King, B. A.	Anderson	Madison
Hurst, E. M.	Cloverdale	Putnam	Jordan, Cecil	Denver	Miami	King, Jack	Vevay	Switzerland
*Hurt, L. B.	Indianapolis	Marion	*Jordan, Leo E.	Lyun	Randolph	*King, Joseph W.	Anderson	Madison
Hurt, Paul T.	Indianapolis	Marion	Jordan, Minnetta	Wabash	Wabash	King, M. O.	Rochester	Fulton
Husted, Robert	Hammond	Lake	Flinn			*King, P. C.	Swayzee	Grant
Hutcheson, W. R.	Greencastle	Putnam	Josif, Lazar	East Chicago	Lake	King, Wm. E.	Indianapolis	Marion
Hutchings, B. M.	Terre Haute	Vigo						

Name	City	County	Name	City	County	Name	City	County
Kingsbury, J. K.	Indianapolis	Marion	*Lamey, James L.	Anderson	Madison	*Little, John W., Jr.	Indianapolis	Marion
Kinnaman, H. A.	Crawfordsville	Montgomery	*Lamey, P. T.	Anderson	Madison	Little, W. D.	Indianapolis	Marion
*Kinneman, R. E.	Greenfield	Hancock	Landis, W. C.	Syracuse	Kosciusko	*Litzenberger, S. W.	Anderson	Madison
Kinsey, Joseph H.	Richmond	Wayne-Union	Lane, W. H. (H)	Angola	Steuben	Lochry, R. L.	Indianapolis	Marion
*Kirch, L. N.	Indianapolis	Marion	*Lane, Wm. H.	South Bend	St. Joseph	*Loehr, W. M.	Indianapolis	Marion
Kirkpatrick, A. M. (H)	Columbus	Bartholomew	*Lang, Joseph E.	South Bend	St. Joseph	*Loewenstein, W. L.	Terre Haute	Vigo
*Kirshman, F. E.	Muncie	Delaware-Blackford	Lang, Shirley C.	Evansville	Vanderburgh	Logan, A. R.	Petersburg	Pike
			Langdon, H. K.	Indianapolis	Marion	Logan, F. W.	Mishawaka	St. Joseph
			*Langenbalm, C. J.	South Bend	St. Joseph	*Logan, Jesse R.	Evansville	Vanderburgh
*Kirtley, J. M.	Crawfordsville	Montgomery	Langsdon, Fred	Gaston	Delaware-Blackford	Lohman, Maurice	Fort Wayne	Allen
Kiser, E. F.	Indianapolis	Marion				*Lohman, Robert M.	Indianapolis	Allen
*Kissinger, K. L.	Angola	Steuben	*Lansford, John	Redkey	Jay	Lomax, Claude C.	Indianapolis	Spencer
*Kistler, James J.	La Porte	La Porte	Lapenta, V. A.	Indianapolis	Marion	Long, J. A. (H)	Anderson	Madison
*Kistner, Arthur W.	Elkhart	Elkhart	*Lapid, G. G.	East Chicago	Lake	*Long, Leonard	Bluffton	Wells
Kistner, John W.	Elkhart	Elkhart	Larkin, Bernard J.	Indianapolis	Marion	*Long, Paul L.	Anderson	Madison
*Kitterman, Harry E.	Indianapolis	Marion	*Larmore, J. L.	Muncie	Delaware-Blackford	Long, W. H.	Indianapolis	Marion
Klahr, Elsworth	South Bend	St. Joseph				Loomis, DeWitt	Boonville	Warriek
*Klain, B. V.	Indianapolis	Marion	Larrabee, W. H.	New Palestine	Hancock	Loomis, J. F. (H)	Marion	Grant
Klein, Else	South Bend	St. Joseph	Larrison, G. D.	Morocco	Jasper	Loomis, N. S.	Indianapolis	Marion
Klein, H. P.	Fort Branch	Gibson				Loop, Floyd A.	La Fayette	Tippecanoe
Kleindorfer, R. L.	Evansville	Vanderburgh	Larson, G. O.	La Porte	La Porte	Loop, Frederick A.	La Fayette	Tippecanoe
Kleinman, F. J.	Hebron	Porter	*LaSalle, R. M.	Wabash	Wabash	Lord, G. C.	Indianapolis	Marion
Kleplinger, H. E.	La Fayette	Tippecanoe	Laubscher, C. S.	Evansville	Vanderburgh	*Lorenty, T. B.	Gary	Lake
Klinger, Maurice O.	Plymouth	Marshall	*Laubscher, Clarence	Evansville	Vanderburgh	*Loring, Mark L.	Valparaiso	Porter
Knapp, A. B. (H)	Vincennes	Knox	Laudeman, W. A.	Elwood	Madison	*Loudermilk, J. L.	Indianapolis	Marion
Knapp, Arthur L.	South Bend	St. Joseph	Lauer, A. J.	Lewisburg, Pa.	Lake	*Love, George N.	Connersville	Fayette-Franklin
Knepple, L. R.	Kokomo	Howard	Lauer, D. B.	Dana	Parke-Vermillion			
Knodel, Kenneth T.	South Bend	St. Joseph				Love, John R.	Terre Haute	Vigo
Knoefel, Peter	Louisville, Ky.	Vigo	Lavengood, R. W.	Marion	Grant	Lovell, Martin H.	Gary	Lake
Knott, Harry	Plymouth	Marshall	Lawler, George F.	Indianapolis	Marion	Loving, J. B.	New Goshen	Vigo
*Kobrak, H. F.	Gary	Lake	*Lawrence, Joseph C.	Evansville	Vanderburgh	*Luckett, C. L.	Boonville	Warriek
*Kobrin, M. W.	Gary	Lake	Laws, H. J.	La Fayette	Tippecanoe	Luckett, Coen L.	Terre Haute	Vigo
*Koehler, Elmer G.	Elkhart	Elkhart	Laws, Kenneth F.	La Fayette	Tippecanoe	Luckey, H. A.	Wolf Lake	Noble
Kohlstaedt, George	Indianapolis	Marion	Lawson, I. H.	Kendallville	Noble	Luckey, R. C.	Wolf Lake	Noble
Kohlstaedt, K. G.	Indianapolis	Marion	Lawson, W. T. (H)	Danville	Hendricks	Ludwig, Oscar D.	Indianapolis	Marion
Kohne, G. J.	Decatur	Adams	Lazo, V. R.	Wheatland	Knox	Lukemeyer, E. G. (H)	Huntingburg	Dubois
Kolettis, George J.	Gary	Lake	Leasure, J. K.	Indianapolis	Marion	Lukemeyer, L. C. (H)	Huntingburg	Dubois
Komoroske, J. E.	East Chicago	Lake	Leatherman, C. A.	Muncie	Delaware-Blackford	Lukemeyer, St. John	Jasper	Dubois
Koons, Karl M.	Indianapolis	Marion				Lukemeyer, Emory D.	Indianapolis	Marion
*Kopcha, Joseph E.	Whiting	Lake	Leatherman, H. L.	Indianapolis	Marion	*Lund, L. C.	Argos	Marshall
Kopp, O. A.	Anderson	Madison	Leckrone, M. E.	Rochester	Fulton	*Lundt, Milo O.	Elkhart	Elkhart
*Korn, Jerome M.	Gary	Marion	LeClaire, Henri	Bicknell	Morgan	Lung, B. D.	Kokomo	Howard
Kornafel, L. H.	Indianapolis	Marion	Lee, A. H.	Terre Haute	Vigo	Lutes, D. L.	Dublin	Wayne-Union
*Kraft, Bennett	Indianapolis	Marion	*Lee, Glen Ward	Richmond	Wayne-Union			
Kraft, Haldon C.	Noblesville	Allen				Lutz, Georgianna	Gary	Lake
Kraft, R. W.	Hobart	Lake	Lee, John M.	Dayton, Ohio	Rush	Luzadder, J. E.	Bloomington	Monroe
Kramer, A. A.	Oak Ridge, Tenn.	St. Joseph	*Lefell, James M.	Indianapolis	Marion	Luzadder, J. E., Jr.	New Carlisle	St. Joseph
			*Lehmberg, O. F.	Columbia City	Whitley	Lybrook, D. E.	Young America	Cass
Kraning, Kenneth	Kewanna	Fulton	*Leich, Charles F.	Evansville	Vanderburgh	Lynch, Harold D.	Evansville	Vanderburgh
Kratzer E. F.	Waynecong	Miami	Leiter, Arthur	Columbia City	Whitley	Lynch, Otho R.	La Fayette	Tippecanoe
*Kreible, Wm. Wymond	Clay City	Clay	Lenmon, B. E.	Indianapolis	Marion	*Lynch, O. R.	Marengo	Crawford
Kremer, N. A.	Madison	Jefferson	Lennon, Herbert K.	Goshen	Elkhart	Lynch, Paul	Evansville	Vanderburgh
*Kress, George L.	Warsaw	Kosciusko	*Lenk, George G.	Fort Wayne	Allen	Lynn, F. M.	Peru	Miami
Kretsch, R. W.	Hammond	Lake	Leonard, Henry S.	Indianapolis	Marion	Lyon, Florence	Portland	Jay
Krieger, George M.	Michigan City	La Porte	*Leser, R. U.	Indianapolis	Marion	Lyons, Charles	Parker	Delaware-Blackford
Krueger, Frederick W.	Richmond	Wayne-Union	*Leslie, Ernil	Evansville	Vanderburgh			
			*Lett, Emory B.	Loogootee	Daviess-Martin	Lyons, R. E., Jr.	Bloomington	Monroe
Kruse, E. H.	Fort Wayne	Allen						
Kruse, Walter E.	Fort Wayne	Allen	Levering, Guy P.	La Fayette	Tippecanoe	MacBeth,		
Kubik, Francis J.	Westville	La Porte	*Levi, Leon	Indianapolis	Marion	Albert H. (H)	Fort Wayne	Allen
*Kudele, L. T.	Whiting	Lake	Levin, Eli	East Chicago	Lake	MacDonald, J. A.	Indianapolis	Marion
Kuhn, Hedwig S.	Hammond	Lake	Lewis, J. R.	Indianapolis	Marion	Mace, E. E.	New Palestine	Hancock
Kuhn, Hugh A.	Hammond	Lake	*Lewis, James F.	Liberty	Wayne-Union	Macer, Clarence G.	Evansville	Vanderburgh
*Kuhn, R. W.	Wilkinson	Hancock				Mac Gregor, D. E.	Indianapolis	Marion
Kunkler, Joseph	Terre Haute	Vigo	Lewis, Robert J.	Indianapolis	Marion	*Machlan, H. F.	Indianapolis	Marion
Kunkler, Wm. C.	Terre Haute	Vigo	*Libbert, E. L.	Lawrenceburg	Dearborn-Ohio	Machledt, J. H.	Whiteland	Johnson
Kuntz, Herman W.	Indianapolis	Marion				*MacKenzie, Pierce	Evansville	Vanderburgh
Kurtz, Fred B.	Indianapolis	Marion	*Libnoch, Casimir	South Bend	St. Joseph	Mackey, C. G.	Culver	Marshall
Kurtz, Philip L.	Indianapolis	Marion	*Lichtenberg, Melvin	Indianapolis	Marion	Mackey, Harry S.	Indianapolis	Marion
Kurtz, William A.	Tipton	Tipton	Lieberman, Arnold L.	Tucson, Ariz.	Lake	Macey, George	Columbus	Bartholomew
*Kwitny, I. J.	Indianapolis	Marion	Life, Homer	New Castle	Henry	*Magennis, H. L.	Indianapolis	Marion
			Lill, J. C.	Fort Wayne	Allen	*Maboney, Charles L.	Terre Haute	Vigo
*LaBier, C. Russell	Terre Haute	Vigo	Lincoln, Charles S., Jr.	Jeffersonville	Clark	Mahuron, Boyd L.	Greensburg	Decatur
LaBier, Clarence R.	Terre Haute	Vigo	Lindenmuth, E. Oscar	Indianapolis	Marion	Maierhofer, Elmer R.	Walkerton	La Porte
LaBonte, Napoleon	Indianapolis	Marion	Lindquist, N. S.	South Bend	St. Joseph	Maisterek, S. L.	Gary	Lake
*Ladig, Donald S.	Fort Wayne	Allen	*Lindsay, H. B.	Washington	Daviess-Martin	*Malcolm, Russell	Richmond	Wayne-Union
*LaDine, C. B.	Indianapolis	Marion						
LaDuron, Jules	Muncie	Delaware-Blackford	Line, H. E.	Chili	Miami	Malmstone, F. A.	Griffith	Lake
			Lingeman, Byron N.	Crawfordsville	Montgomery	Malone, L. A.	Terre Haute	Vigo
*LaFata, F. Paul	Gary	Lake	Lingeman, E. L.	Indianapolis	Marion	*Malott, Fred	Converse	Miami
Laird, L. A.	North Webster	Kosciusko	Link, Goethe	Indianapolis	Marion	Malouf, S. D.	Peru	Miami
Lake, G. H.	Pleasant Lake	Steuben	Linn, E. E.	La Porte	La Porte	*Malstaff, C. M.	South Bend	St. Joseph
Lamb, E. B.	Indianapolis	Marion	Linton, C. D.	Walkerton	St. Joseph	*Maly, C. H.	Indianapolis	Marion
Lamb, Russell	Indianapolis	Marion	Linton, C. E.	Medaryville	Pulaski	Manion, Marlow W.	Indianapolis	Marion
*Lamber, C. K.	Indianapolis	Marion	*List, Harold E.	Marion	Grant	*Manley, C. N.	Rising Sun	Dearborn-Ohio
Lambert, J. L. (H)	Brazil	Clay	Littell, J. J.	Indianapolis	Grant			
Lambright,	Danville, Ill.	Fountain-Warren	Little, J. A.	Evansville	Cass			
Simcon (H)			Little, John W.	Indianapolis	Marion	Mann, Mortimer	Indianapolis	Marion

Name	City	County	Name	City	County	Name	City	County
Manning, Joseph C.	Indianapolis	Marion	McCoy, Roy R.	Fort Wayne	Allen	Metcalfe, G. E.	South Bend	St. Joseph
*Mansfield, Max R.	Indianapolis	Marion	McCracken, J. O.	Montgomery	Daviess-	Meyer, Herman A.	Fort Wayne	Allen
Mansfield, Thomas (H)	Indianapolis	Delaware-			Martin	Meyer, K. T.	Evansville	Vanderburgh
		Blackford	McCulloch, C. B.	Indianapolis	Marion	*Meyer, O. L.	Portland	Jay
Maple, J. B.	Sullivan	Sullivan	McCullough, J. Y.	New Albany	Floyd	Meyer, R. C.	Vincennes	Knox
Marchand, Austin F.	Haubstadt	Gibson	McDaniel, F. P.	Atlanta	Hamilton	*Michaels, S. C.	Fort Wayne	Allen
Marchand, Edwin V.	Haubstadt	Gibson	McDevitt, D. R.	Indianapolis	Marion	Michaels, J. F.	Edinburg	Johnson
*Marchant, C. H.	Bloomington	Monroe	*McDonald, J. D.	Evansville	Vanderburgh	Micheli, A. J.	Indianapolis	Marion
Marcus, M. C.	Gary	Lake	*McDonald, R. M.	Mishawaka	St. Joseph	Middleton, H. N.	Indianapolis	Madison
*Maris, Lee J.	Attica	Fountain-	McDonald, V. G.	Anderson	Madison	Mikesch, W. H.	South Bend	St. Joseph
		Warren	*McDowell, George A.	Fort Wayne	Allen	Miley, W. M.	Anderson	Madison
Markel, I. J.	Elkhart	Elkhart	McDowell, M. A.	Logansport	Cass	Miller, Albert W.	Indianapolis	Marion
Markley, H. W.	Rochester	Fulton	McDowell, Walter	Evansville	Vanderburgh	Miller, A. G.	Hobart	Lake
*Marks, H. H.	Evansville	Vanderburgh	*McElroy, J. S.	New Castle	Henry	*Miller, Carl G.	Fort Wayne	Allen
Marks, Ora L.	East Chicago	Lake	*McElroy, R. S.	Princeton	Gibson	Miller, Charles A.	Princeton	Gibson
Marsh, Chester A.	Hagerstown	Henry	*McEwen, J. W.	Terre Haute	Vigo	Miller, D. B.	Terre Haute	Vigo
*Marsh, George	Otterbein	Benton	*McFadden, James M.	Fort Wayne	Allen	Miller, Donald L.	Twelve Mile	Cass
*Marsh, J. P.	Blountsville	Henry	*McFall, V. F.	Anderson	Madison	Miller, E. H.	Valparaiso	Porter
*Marshall, A. L.	Indianapolis	Marion	McFarland, Corley B.	South Bend	St. Joseph	Miller, H. A.	Marion	Grant
Marshall, Augustus L.	Indianapolis	Marion	McGanghey, W. M.	Greencastle	Putnam	Miller, H. L.	West Baden	Orange
Marshall, B. W.	Nashville	Bartholomew	McGuire, D. F.	East Chicago	Lake	Miller, Harold E.	Seymour	Jackson
Marshall, C. R.	Indianapolis	Marion	McIlwain, Eleanor	Marion	Grant	*Miller, Henry P.	Fort Wayne	Allen
Marshall, George	Bourbon	Marshall	McIlwain, Robert	Marion	Grant	Miller, J. Don	Indianapolis	Marion
Marshall, L. C.	Mount Summit	Henry	McIndoo, R. E.	Kokomo	Howard	Miller, L. B.	Evansville	Vanderburgh
*Marshall, William P.	Indianapolis	Marion	McIntyre, Charles J.	Indianapolis	Marion	Miller, L. R.	Winslow	Pike
Martin, C. E.	Lynn	Randolph	*McIntyre, J. M.	Indianapolis	Marion	*Miller, M. E.	Goshen	Elkhart
Martin, F. V. (H)	Michigan City	La Porte	McKay, J. D.	Marion	Grant	Miller, Mahlon F.	Fort Wayne	Allen
Martin, Frank D.	Bedford	Lawrence	McKean, T. J.	Montpelier	Adams	Miller, Milton	Evansville	Vanderburgh
*Martin, Floyd S.	Goshen	Elkhart	McKee, C. E. (H)	Dublin	Wayne-Union	Miller, Milo	South Bend	St. Joseph
Martin, Guy	Seymour	Jackson	McKee, H. S.	Greensburg	Decatur	Miller, Minor	Evansville	Vanderburgh
Martin, H. G.	La Fayette	Tiptecanoe	*McKeeman, D. H.	Fort Wayne	Allen	*Miller, Orval J.	Fort Wayne	Allen
*Martin, L. H.	Indianapolis	Marion	McKeeman, L. S.	Fort Wayne	Allen	*Miller, Raymond D.	Martinsville	Marion
Martin, W. B.	La Porte	La Porte	*McKinley, A. D.	Indianapolis	Marion	*Miller, R. B.	Argos	Marshall
Martin, Will J.	Kokomo	Howard	*McKinney, D. H.	La Fayette	Tiptecanoe	Miller, R. S.	Indianapolis	Marion
Martz, Carl D.	Indianapolis	Marion	McKinney, S. L.	Huntingburg	Dubois	*Miller, Richard C.	Indianapolis	Marion
*Mason, Everett E.	Evansville	Vanderburgh	*McKittrick, Jack	Washington	Daviess-	*Miller, Richard H.	Fort Wayne	Allen
Mason, L. R.	Muncie	Delaware-			Martin	*Miller, Robert J.	Evansville	Vanderburgh
		Blackford	McKittrick, Wm. O.	Washington	Daviess-	Miller, S. J.	West Lafayette	Tiptecanoe
*Mast, Karl F.	Fort Wayne	Allen			Martin	Miller, S. T.	Elkhart	Elkhart
*Masters, J. M.	Indianapolis	Marion	*McLaughlin, C. P.	Pendleton	Madison	Miller, Virgil	Akron	Fulton
Masters, R. J.	Indianapolis	Marion	*McLaughlin, James R.	Logansport	Cass	Miller, Wm.	Hagerstown	Wayne-
Mates, Edward	Evansville	Vanderburgh	McMeel, J. E.	South Bend	St. Joseph			Union
Mather, J. W.	East Gary	Lake	McMichael, F. J.	Gary	Lake	*Miller, Wm. E.	South Bend	St. Joseph
Mathews, W. C.	Kentland	Jasper-	*McMichael, R. M.	Muncie	Delaware-	Miller, Wm. T.	Indianapolis	Montgomery
		Newton			Blackford	*Mills, Robert	Crawfordsville	Henry
Mathys, Alfred	Mauckport	Harrison	McMillan, F. G.	Indianapolis	Marion	*Mills, J. F.	New Castle	Vanderburgh
*Matthew, J. R.	Knox	Starke	McMurtry, L. K.	Evansville	Vanderburgh	Mino, Victor H.	Evansville	Lake
*Matthew, W. B.	Indianapolis	Marion	McNabb, G. B.	Carthage	Rush	Mirro, John A.	Lowell	Elkhart
Matthews, B. J.	Indianapolis	Marion	McNaull, Charles (II)	Indianapolis	Marion	*Miskin, Irving	Elkhart	Vigo
Matthews, Chas. B.	Hammond	Lake	McNeely, M. J.	Dillsboro	Dearborn-	Mitchell, Albert M.	Terre Haute	Tiptecanoe
Matthews, D. W.	North Vernon	Jennings			Ohio	Mitchell, E. T.	Romney	Marion
*Mattox, Don M.	Terre Haute	Vigo	McPherson, S. L. (II)	Washington	Daviess-	Mitchell, Earl H.	Indianapolis	Monroe
Maurer, J. F.	Brazil	Clay			Martin	Mitchell, G. L.	Smithville	St. Joseph
Mavity, D. E.	Fowler	Benton	McQueen, William	Jamestown,	Marion	Mitchell, H. F. (H)	South Bend	Washington
Maxwell, J. B. (H)	Logansport	Cass		N. C.		Mitchell, J. I.	Salem	Marion
May, Frank	Palmyra	Harrison	*McQuiston, R. J.	Indianapolis	Marion	Mitchell, R. E.	Indianapolis	Huntington
May, George A.	Madison	Jefferson	McVey, C. A.	Hammond	Lake	Moats, F. B.	Huntington	Allen
May, R. M.	Hobart	Lake	*McWilliams, W. B.	Liberty	Wayne-	Moats, C. F.	Fort Wayne	Allen
					Union	Moats, G. E.	Fort Wayne	Allen
McAlexander,	Indianapolis	Marion				Mobley, L. F.	Summitville	Madison
R. O. (H)						Mock, E. L.	Dallas,	Knox
*McArdle, Edward G.	Fort Wayne	Allen	Mead, C. H.	Bluffton	Wells		Texas	
*McBane, John	Fortville	Hancock	*Meade, W. W.	Bicknell	Knox	*Modjeski, Raymond J.	Hammond	Lake
McBride, E. C.	Terre Haute	Vigo	Medealf, N. L.	Lamar	Spencer	*Moehlenkamp, Chas. E.	Evansville	Vanderburgh
McBride, James S.	Indianapolis	Marion	*Mengenhardt, D. S.	Indianapolis	Marion	Moenning, W. P.	Indianapolis	Marion
McBride, Noel S.	Terre Haute	Vigo	Mehl, Rudolph A.	Evansville	Vanderburgh	Mohr, Ann L. M.	Shelbyville	Shelby
McCabe, J. E.	Otterbein	Benton	Meikle, Louise J.	W. Lafayette	Tiptecanoe	Molloy, W. J.	Muncie	Delaware-
*McCabe, Theodore E.	Fort Wayne	Allen	Meiks, Lyman T.	Indianapolis	Marion		Blackford	
McCallum,	Indianapolis	Marion	Meiner, J. A.	Kokomo	Howard	Molt, W. F.	Indianapolis	Marion
Joseph T. C.			Meiser, Robert	Huntington	Huntington	*Montgomery, J. R.	Princeton	Gibson
McCarthy, D. J.	Indianapolis	Marion	Meister, Doris	Anderson	Madison	Montgomery, L. G.	Muncie	Delaware-
McCarthy, F. G.	Terre Haute	Vigo	*Melloh, A. F.	Indianapolis	Marion		Blackford	
McCarthy, Jeremiah A.	Whiting	Lake	*Mendenhall, C. D.	Indianapolis	Marion	Montgomery, S. B.	Cynthiana	Posey
*McCartney, Donald H.	Indianapolis	Marion	Mendenhall, Edgar	Fort Wayne	Allen	Montgomery, Wm. F.	Indianapolis	Marion
*McCarty, Virgil	Princeton	Gibson	Mendenhall, W. E.	Indianapolis	Marion	Moore, B. B.	Indianapolis	Marion
McCaskey, C. H.	Indianapolis	Marion	Mentendiek, M. H.	Indianapolis	Marion	*Moore, H. T.	Indianapolis	Marion
McCaskey, G. H.	Winamac	Pulaski	Mendez, Carlos	Elkhart	Elkhart	Moore, Martha	Butler	Jennings
McCay, O. L.	Romney	Tiptecanoe	Merceer, Samuel R.	Fort Wayne	Allen	Moore, Paul D.	Muncie	Delaware-
McClain, Marvin	Scottsburg	Scott	Merchant, Raymond	Lake Village	Jasper-		Blackford	
McClelland, D. C.	La Fayette	Tiptecanoe			Newton	Moore, R. G.	Vincennes	Knox
McClure, S. E.	Monon	Tiptecanoe	*Meredith, E. J.	Richmond	Wayne-	Moore, Robert M.	Indianapolis	Marion
*McConnell, Wm. C.	Summan	Ripley			Union	Moore, W. C.	Muncie	Delaware-
*McCool, J. H.	Evansville	Vanderburgh	*Meriele, Earl	Indianapolis	Marion		Blackford	
McCool, W. E.	Evansville	Vanderburgh	*Merrell, B. M.	Brownstown	Jackson	Mooscy, Louis	Union Mills	La Porte
McCormick, C. O.	Indianapolis	Marion	Merrell, Paul	Indianapolis	Marion	Moran, Mark M.	Portland	Jay
McCormick, H. D.	Vincennes	Knox	Mertz, H. O.	Indianapolis	Marion	Moran, Noel D.	Versailles	Ripley
*McCormick, W. C.	Terre Haute	Vigo	Mervis, F. H.	East Chicago	Lake	Moran, Richard J.	Rockville	Parke-
McCown, P. E.	Indianapolis	Marion	Messer, F. W.	Kendallville	Noble		Vermillion	
			Metcalfe, George B.	Anderson	Madison	*Moravec, Arthur E.	Fort Wayne	Allen

Name	City	County	Name	City	County	Name	City	County
Morgan, Herman G.	Indianapolis	Marion	*Nelson, Paul Leon	Anderson	Madison	Owen, Margaret T.	Bloomington	Monroe
Morgan, Isabel	Ann Arbor	Hendricks	*Nelson, R. B.	Hammond	Lake	Owens, John B.	Feedersburg	Fountain-
	Michigan		*Nelson, Raymond	South Bend	St. Joseph		Warren	
Morgan, Marion	Evansville	Vanderburgh	Nemcker, Henry	Evansville	Vanderburgh	Owens, Thomas R.	Muncie	Delaware-
Morgan, S. P.	La Porte	La Porte	*Nesbit, L. L.	Anderson	Madison		Blackford	
Mononey, J. H. (II)	Winchester	Randolph	Nesbit, O. B.	Gary	Lake	Owsley, Charlotte	Hartford City	Delaware-
Morr, J. W.	Albion	Noble	Netherton, C. R.	Chalmers	Tippecanoe		Blackford	
Morris, Charles W.	Penns Grove,	Parke-	*Neumann, K. O.	La Fayette	Tippecanoe	*Owsley, Guy A.	Hartford City	Delaware-
	N. J.	Vermillion	Newalt, Frank	Gary	Lake		Blackford	
Morris, G. B.	Bluffton	Wells	Newby, A. C.	Sheridan	Hamilton	*Owsley, Robert	Hartford City	Delaware-
Morris, J. B.	Hammond	Lake	Newcomb, John R.	Indianapolis	Marion		Blackford	
Morris, J. W.	Hartford City	Delaware-	*Newcomb, Wm. K.	Royal Center	Cass	*Oyer, J. H.	Fort Wayne	Allen
		Blackford	Newland, A. E.	Bedford	Lawrence			
*Morris, Marion H.	Indianapolis	Marion	Newman, A. E.	Evansville	Vanderburgh	Pace, J. V.	New Albany	Floyd
Morris, W. F.	Fort Branch	Gibson	Niblack, E. S.	Terre Haute	Vigo	Padgett, E. E.	Indianapolis	Marion
*Morris, Warren V.	Monticello	Tippecanoe	Niblack, J. S.	East Chicago	Lake	*Paif, W. A.	Elkhart	Elkhart
Morrison, C. C.	Greensburg	Decatur	Nichols, Wm. E.	Hammond	Lake	Page, Irvine H.	Indianapolis	Marion
*Morrison, D. A.	Kokomo	Howard	Nickel, Allen C.	Bluffton	Wells	Palmeier, J. W.	Sandborn	Knox
*Morrison, G. G.	Portland	Jay	*Niecia, J. B.	East Chicago	Lake	Painter, L. W.	Winchester	Randolph
Morrison, John S.	Lafayette	Tippecanoe	Nie, Grover	Huntington	Huntington	*Paletz, Benjamin	Michigan City	La Porte
Morrison, J. T.	Greensburg	Decatur	*Nie, Louis W.	Huntington	Huntington	*Palm, John M.	Brazil	Clay
Morrison, Lindsey	Hammond	Lake	Niedermeyer, Alfred	Evansville	Vanderburgh	Palmer, Earl	Logansport	Cass
Morrison, W. R.	Kokomo	Howard	*Nigh, R. M.	Fairland	Shelby	*Panares, Solomon V.	Hammond	Lake
Morrow, R. D.	Connersville	Fayette-	*Nill, John H.	Fort Wayne	Allen	*Pancost, Vernon K.	Elkhart	Elkhart
		Franklin	Nixon, Byron	Farmland	Randolph	*Pandolfo, Harry	Indianapolis	Marion
Mortenson, L. J.	Fort Wayne	Allen	Nixon, J. E.	Portland	Jay	*Paris, D. W.	Kokomo	Howard
Morton, Walter P.	Indianapolis	Marion	Noble, T. B.	Indianapolis	Marion	Parker, Carl B.	Wingate	Montgomery
Moser, E. B.	Windfall	Tipton	Noble, T. B., Jr.	Indianapolis	Marion	Parker, C. B.	Fort Wayne	Allen
Moser, Edward	Woodburn	Allen	Noblitt, J. S.	Waveland	Montgomery	*Parker, Carl E.	South Bend	St. Joseph
Moser, R. H.	Indianapolis	Marion	Nodinger, Louis	Hammond	Lake	Parker, E. E.	Oxford	Benton
Moses, George E.	Worthington	Greene	Nolt, E. V.	Columbia City	Whitley	Parker, G. F.	Greencastle	Putnam
*Moss, M. J.	Yorktown	Delaware-	Nolting, H. F.	Indianapolis	Marion	Parker, H. C.	Gary	Lake
		Blackford	Norman, O. B.	Indianapolis	Marion	Parker, H. E.	Lafayette	Tippecanoe
Mothersill, M. H.	Indianapolis	Marion	*Norman, Wm. H.	Indianapolis	Marion	Parker, H. P.	Urbana	Wabash
Mott, C. A.	South Bend	St. Joseph	Norris, Allen A.	Elkhart	Elkhart	*Parker, J. F.	Indianapolis	Marion
*Mount, M. S.	Bloomfield	Greene	*Norris, Ernest B.	Middlebury	Elkhart	Parker, Portia	Indianapolis	Marion
*Mount, Wm.	Crawfordsville	Montgomery	Norris, H. L.	Indianapolis	Marion	Parkison, W. M.	Belen,	New Mex.
Mount, Wm. C.	Kirklin	Clinton	Norris, Mary A.	Indianapolis	Marion			Porter
Mountain, Francis	Connersville	Fayette-	Northrup, A. H.	Indianapolis	Marion	Parrish, Richard K.	Decatur	Adams
		Franklin	Norton, Horace	Indianapolis	Marion	Patrick, G. B.	Elkhart	Elkhart
Moutoux, J. E.	Indianapolis	Marion	Norton, Wm. J. (H)	Indianapolis	Marion	Patterson, William K.	Indianapolis	Marion
Mower, Giles E.	Jeffersonville	Clark	*Norwick, Sydney	Indianapolis	Marion	Patten, V. C.	Morristown	Shelby
Mozingo, A. E.	Indianapolis	Marion	*Nourse, Myron H.	Indianapolis	Marion	Patton, Martin T.	Indianapolis	Marion
Muelchi, Adeline F.	Evansville	Vanderburgh	*Nugen, Harold	Auburn	De Kalb	*Paulissen, George T.	Indianapolis	Marion
*Mueller, Lawrence	Fort Wayne	Allen	*Nutter, W. H.	Rushville	Rush	Pauszek, Thomas B.	South Bend	St. Joseph
Mueller, Lillian B.	Indianapolis	Marion	Nyce, Holtz Wm.	Van Buren	Grant	Payne, A. C.	East Chicago	Lake
*Muhleman, C. E.	La Porte	La Porte	Nye, J. H. (H)	Cromwell	Noble	Paynter, Claude B.	Salem	Washington
*Mulcaby, B. J.	Muncie	Delaware-				Paynter, L. W.	Salem	Washington
		Blackford	Oak, D. D.	La Crosse	La Porte	Paynter, Morris B.	Southport	Marion
Mull, P. L.	Pekin	Washington	Obery, George	Oldenburg	Franklin	*Peacock, Robert	Indianapolis	Marion
*Muller, Lullus P.	Fowler	Marion	O'Brien, Tracy	Danville	Putnam	*Peacock, Norman F.	Crawfordsville	Montgomery
Mullikin, C. W.	Greensburg	Decatur	Ochsner, Harold C.	Indianapolis	Marion	*Peak, Ira F.	Indianapolis	Marion
Mullikin, H. M.	Terre Haute	Vigo	O'Connor, James J.	East Chicago	Lake	Pearce, Roy V.	Indianapolis	Marion
Mullin, H. Y.	Rockfield	Carroll	O'Dell, Harry	Farmersburg	Sullivan	Pearlman, Samuel	La Fayette	Tippecanoe
Mumford, E. B.	Indianapolis	Marion	O'Dell, Harry W.	Jersey City,	Sullivan	Pearson, John R.	Bedford	Lawrence
Muncie, H. L.	Brazil	Clay		N. J.		Pearson, Lyman R.	Indianapolis	Marion
Munk, C. E.	Kendallville	Noble	O'Dell, Thomas A.	*Indianapolis	Marion	*Pearson, Wm.	Wabash	Wabash
Murdock, H. L.	Fort Wayne	Allen	O'Hale, John A.	Richmond	Wayne-Union	Pebworth, A. C.	Indianapolis	Marion
*Murphy, E. C.	South Bend	St. Joseph	*Oleott, C. W.	Aurora	Dearborn-	*Pebworth, J. T.	Indianapolis	Marion
Murphy, E. W.	Lanesville	Harrison			Ohio	Peck, Franklin B.	Indianapolis	Marion
Murphy, Harry	Franklin	Johnson	O'Leary, F. T.	Logansport	Cass	Pectol, Charles F.	Spencer	Owen
Murphy, Josephine	South Bend	St. Joseph	*Oliphant, F. W.	Mount Vernon	Posey	*Pekarek, Edward A.	Whiting	Lake
Murphy, M. G.	Morgantown	Morgan	Oliphant, J. T.	Farmersburg	Sullivan	Pell, H. M.	Brazil	Clay
Murphy, S. C.	Warsaw	Kosciusko	*Oliphant, R. W.	Terre Haute	Vigo	*Pence, Benjamin F.	Columbia City	Whitley
Murray, F. N.	Kokomo	Howard	Oliver, E. W.	Evansville	Vanderburgh	Pennell, John P.	Kokomo	Howard
Musselman, G. G.	Terre Haute	Vigo	Olson, K. L.	South Bend	St. Joseph	Pennington, L. E.	Madison	St. Joseph
Myers, B. D.	Bloomington	Monroe	*Olvey, Otis N.	Noblesville	Hamilton	Pennington, V. M.	Madison	St. Joseph
Myers, Charles W.	Indianapolis	Marion	*Openshaw, J. F.	Goodland	Tippecanoe	Pennington, W. E.	Indianapolis	Marion
Myers, R. V.	Indianapolis	Marion	Oppenheimer, Ernst	Evansville	Posey	*Pentecost, Paul S.	Richmond	Wayne-
Myers, Wm. C.	Dana	Parke-	Orders, C. E.	Indianapolis	Marion		Union	
		Vermillion	*O'Rourke, Carroll	Fort Wayne	Allen	Permer, Erwin	Indianapolis	Marion
			*Orr, W. Robert	Detroit,	St. Joseph	*Perrin, K. F.	Fort Wayne	Allen
				Mich.		*Perry, F. G.	Plymouth	Marshall
Nafe, C. A.	Indianapolis	Marion	Osborne, Harry S.	Indianapolis	Marion	Perry, I. E.	No. Manchester	Wabash
*Nahrwold, Elmer W.	Fort Wayne	Allen	Osterman, Louis	Seymour	Jackson	Peters, R. J. D.	Indianapolis	Marion
Nance, W. K.	Vincennes	Knox	Ostrowski, L. J.	East Chicago	Lake	Peterson, Joel A.	Lafayette	Tippecanoe
Napper, Floyd	Scottsburg	Scott	Ostrowski, R. O.	Hammond	Lake	*Petitjean, H. G.	Haubstadt	Gibson
*Nash, Charles B.	Valparaiso	Porter	*Oswalt, J. T.	Dunkirk	Jay	Petrano, T. V.	Indianapolis	Marion
Nash, Justin R.	Albion	Noble	Otten, Claude F.	Indianapolis	Marion	Petrass, Andrew	South Bend	St. Joseph
*Nason, R. A.	Garrett	De Kalb	Otten, Ralph E.	Darlington	Montgomery	Petronella, S. J.	East Chicago	Lake
Naugle, R. A.	Wabash	Wabash	Ottinger, R. C.	Indianapolis	Marion	Pettibone, C. R.	Crown Point	Lake
Nave, H. E.	Fountaintown	Shelby	Otto, Anthony E. (H)	Alexandria	Madison	Pettijohn, B. B.	Indianapolis	Marion
Navin, Hugh K.	Fortville	Hancock	Overman, F. V.	Indianapolis	Marion	Pettijohn, F. L.	Indianapolis	Marion
Nay, E. O.	Terre Haute	Vigo	Overpeck, Charles	Greensburg	Decatur	*Peyton, Frank W.	La Fayette	Tippecanoe
*Need, Louis T.	Indianapolis	Marion	Overpeck, George H.	Alexandria	Madison	*Pfaff, Dudley	Indianapolis	Marion
Neely, A. S.	Indianapolis	Marion	Overshiner, Lyman	Columbus	Bartholomew	Pfaff, John A.	Indianapolis	Marion
Nehil, L. W.	Indianapolis	Marion	*Owen, Abraham	Attica	Fountain-	Pfafflin, C. A.	Indianapolis	Marion
*Nedballa, E. G.	Bristol	Elkhart			Warren		Lawrenceburg	Dearborn-
Neier, O. C. (H)	Indianapolis	St. Joseph						Ohio
Nelson, F. Dale	South Bend	St. Joseph						

Name	City	County	Name	City	County	Name	City	County
*Phillips, J. R.	Mieghian City	La Porte	*Raney, B. B.	Linton	Greene	Riley, E. T. (H)	Greensburg	Decatur
Phillips, W. R.	Greenwood	Fayette-Franklin	Rank, A. A.	Washington	Daviess-Martin	Riley, Frank	Jamestown	Boone
Phipps, D. L. (H)	Union City	Johnson	Ranke, John W. H.	Fort Wayne	Allen	*Rininger, Harold C.	Christiuey	Spencer
Phipps, Leland K.	Union City	Randolph	*Raphael, Isidor J.	Evansville	Vanderburgh	Rinker, E. B.	Indianapolis	Marion
Piazza, Leonard F.	Michigan City	La Porte	*Rarick, Alden J.	Cromwell	Noble	Rinne, John I.	Lapel	Madison
*Picha, V. J.	Muncie	Delaware-Blackford	Rariden, L. B.	Greenfield	Hancock	*Rinne, John I., Jr.	Anderson	Madison
*Pickard, H. M.	Elkhart	Elkhart	Rasmussen, Ruth F.	South Bend	St. Joseph	Rissing, Walter J.	Fort Wayne	Allen
Pierce, H. J.	Terre Haute	Vigo	Ratcliff, A. L.	Kingman	Fountain-Warren	Ristine, Warren H. (H)	Crawfordsville	Montgomery
Pierson, P. R.	New Albany	Floyd	*Ratcliff, Frank W.	La Fayette	Tippecanoe	Ritchey, J. A.	Marion	Grant
*Pierson, Robert H.	Spencer	Owen	Ratcliffe, A. W.	Evansville	Vanderburgh	Ritchey, J. O.	Indianapolis	Marion
Pierson, Thomas A.	New Palestine	Hancock	Rauschenbach, C. W.	Hammond	Lake	Ritter, W. L.	Indianapolis	Marion
*Pitcheh, Jack	Indianapolis	Marion	Ravdin, Bernard	Evansville	Vanderburgh	Robertson, D. W. (H)	Deputy	Jennings
*Pilot, Jean	Chicago, Ill.	Lake	Ravdin, Marcus (H)	Evansville	Vanderburgh	Robertson, M. O.	Bedford	Lawrence
Pippenger, W. G.	Brook	Jasper-Newton	Rawles, Lyman T.	Fort Wayne	Allen	Robertson, Ray	Indianapolis	Marion
Pirkle, H. B.	Rockville	Parke-Vermillion	Ray, H. A.	Fort Wayne	Allen	*Robertson, W. S.	Spiceland	Henry
Pitkin, Edward M.	Martinsville	Morgan	Rayl, C. C.	Decatur	Adams	Robinson, Earl U.	Evansville	Vanderburgh
Pitkin, M. C.	Martinsville	Morgan	Reagan, L. M.	Kokomo	Howard	Robinson, F. C.	Indianapolis	Marion
*Plain, George	South Bend	St. Joseph	Reck, J. L.	Sheridan	Hamilton	Robison, C. A.	Frankfort	Clinton
Ploughe,	Elwood	Madison	Records, A. W.	Franklin	Johnson	Robison, J. S.	Winchester	Randolph
Monroe L. (H)			*Redding, Lowell G.	Huntington	Huntington	Robrock, Lawrence M.	Michigan City	La Porte
Ploughe, R. R.	Elwood	Madison	Reed, Donald	Culver	Marshall	Rockey, Noah A.	Fort Wayne	Allen
*Poland, M. F.	Indianapolis	Monroe	Reed, J. V.	Indianapolis	Marion	Rodenbeck, Frank	Arcadia	Hamilton
Polchmus, Gretchen I.	New Albany	Floyd	Reed, L. D. (H)	Hope	Bartholomew	Rodin, Herman H.	South Bend	St. Joseph
Pollard, Walter	Evansville	Vanderburgh	Reed, Nelle C.	Michigan City	La Porte	Rodriguez, Juan	Fort Wayne	Allen
Pollock, E. L.	Vincennes	Knox	Reed, Philip B.	Indianapolis	Marion	Rogers, Clarke	Indianapolis	Marion
Pollom, Robert R.	Crawfordsville	Montgomery	*Reed, R. R.	Indianapolis	Marion	*Rogers, O. F.	Bloomington	Monroe
Pontius, Minerva B.	Ann Arbor, Michigan	Vanderburgh	*Reed, Wm. C.	Bloomington	Monroe	Rogers, R. C.	Bloomington	Monroe
*Popp, M. F.	Fort Wayne	Allen	*Reeder, H. H.	Jeffersonville	Clark	Rogers, S. T. (H)	New Albany	Floyd
*Porter, Carl M.	Jasonville	Greene	Rees, Russell C.	Indianapolis	Marion	*Rogers, Thomas P.	Indianapolis	Marion
Porter, E. A.	Westport	Decatur	*Regan, George L.	Sellersburg	Clark	*Rohrer, J. R.	Washington	Daviess-Martin
Porter, George C.	Linton	Greene	*Reich, Clarence E.	Evansville	Vanderburgh	Roland, C. F.	Detroit, Mich.	Marion
Porter, G. S.	Williamsport	Fountain-Warren	*Reid, Chas. A.	Indianapolis	Marion	Roll, E. C.	Indianapolis	Marion
Porter, John R.	Lebanon	Boone	Reid, Robert W.	Union City	Randolph	Roller, C. W.	Indianapolis	Marion
Porter, Mac Guyer (H)	Elhona	Daviess-Martin	Reisler, Simon	Indianapolis	Marion	Rollins, Russell	Royal Center	Cass
Porter, M. F.	Fort Wayne	Allen	*Reiss, Jack	Indianapolis	Marion	*Romack, H. H.	Greenfield	Hancock
*Porter, W. L.	College Corner, Ohio	Wayne-Union	Reitz, Thomas F.	Evansville	Vanderburgh	Romberger, F. T.	La Fayette	Tippecanoe
Portteus, Walter L.	Franklin	Johnson	*Remich, A. C.	Hammond	Lake	*Romberger, Floyd T., Jr.	Indianapolis	Marion
Possolt, T. R.	Plymouth	Marshall	*Renbarger, L. L.	Marion	Grant	*Rommel, Clarence H.	West Lafayette	Tippecanoe
Poston, C. L.	Richmond	Wayne-Union	Rendel, C. F.	Mexico	Miami	Ropp, E. R.	Oakland City	Gibson
Powell, E. H.	Valparaiso	Porter	*Rendel, D. T.	Hammond	Lake	*Ropp, H. E.	New Harmony	Posey
Powell, J. Paxton	Indianapolis	Marion	Rentschler, L. C.	Clay City	Clay	Rose, Bertha	West Lafayette	Tippecanoe
Powell, Nettie B. (H)	Marion	Grant	Reppert, Roland	Decatur	Adams	*Rosenak, Bernard D.	Indianapolis	Marion
Prather, S. A.	Vincennes	Knox	Resoner, Wm. S.	Swayzee	Grant	*Rosenbaum, L. E.	Anderson	Madison
*Premuda, F. E.	East Chicago	Lake	Rettig, A. C.	Muncie	Delaware-Blackford	Rosenblatt, B. B.	Evansville	Vanderburgh
Prenatt, Francis	North Madison	Jefferson	*Reul, Thomas W.	Indianapolis	Marion	*Rosenbloom, P. J.	Gary	Lake
Preniss, Nelson H.	Fort Wayne	Allen	Reusser, Amos	Berne	Adams	Rosenheimer, Geo. M.	South Bend	St. Joseph
*Present, Julian	Evansville	Vanderburgh	Reynolds, D. M.	Garrett	De Kalb	*Rosenwasser, Jacob	Mishawaka	St. Joseph
Price, C. R.	Geneva	Adams	*Reynolds, F. C.	Indianapolis	Marion	*Roser, A. J.	Arcola	Allen
*Price, Douglas	Nappanee	Elkhart	Reynolds, F. M.	Montpelier	Wells	*Rosevear, Henry J.	Hammond	Lake
Price, Melvin D.	Nappanee	Elkhart	Reynolds, J. S.	Gary	Lake	*Ross, Alexander T.	Indianapolis	Marion
*Price, Sidney	Marion	Grant	Reynolds, R. P.	Garrett	De Kalb	Ross, Ben R.	Bloomington	Monroe
Price, W. A. (H)	Nappanee	Elkhart	*Rhany, A. P.	Wabash	Wabash	Ross, Guy E.	Anderson	Madison
*Prough, W. A.	Indianapolis	Marion	Rhany, B. W.	Fort Wayne	Allen	Ross, H. P.	Richmond	Wayne-Union
Provine, O. A.	Franklin	Johnson	*Rhea, G. D.	Greencastle	Putnam	Ross, L. F.	Richmond	Wayne-Union
Pryor, David G.	Jeffersonville	Clark	Rhine, James C.	Beech Grove	Marion	Ross, Milton S.	Columbus	Bartholomew
Pryor, R. C.	Indianapolis	Marion	Rhind, A. W.	Hammond	Lake	Ross, W. W.	La Porte	La Porte
Przednowek, A. C.	La Porte	La Porte	Rhodes, A. H.	Princeton	Gibson	Rossiter, D. L.	Fort Wayne	Allen
*Pugh, Willis L.	Evansville	Vanderburgh	Rhodes, Theodore D.	Indianapolis	Marion	*Rossman, Wm. B.	Indianapolis	Marion
Pulsamp, B. H.	Wolcottville	Noble	Rhorer, H. M.	Kokomo	Howard	*Rothberg, Maurice	Fort Wayne	Allen
Purvey, J. O.	Gary	Lake	*Rhorer, R. J.	Kokomo	Howard	Rothschild, C. J.	Fort Wayne	Allen
Puterbaugh, K. E.	Albany	Delaware-Blackford	*Rice, C. L.	Logansport	Cass	Rothstein, Emil	Manteno, Ill.	Parke-Vermillion
*Pyle, Harold D.	South Bend	St. Joseph	Rice, Raymond M.	Indianapolis	Marion	*Rotman, Harry G.	Jasonville	Greene
*Quick, Wm. J.	Muncie	Delaware-Blackford	Rice, Thurman B.	Indianapolis	Marion	Rotman, Sam	Jasonville	Greene
Quickel, Daniel L. (H)	Anderson	Madison	Rice, T. R. (H)	Petersburg	Pike	*Row, D. H.	Indianapolis	Marion
*Quigley, Joseph B.	Indianapolis	Marion	Rice, W. B.	Fort Wayne	Allen	Row, George S.	Osgood	Ripley
*Rabb, Harry	Indianapolis	Marion	*Rich, J. S.	Evansville	Vanderburgh	Row, Perry Q.	Hammond	Lake
*Radivojevic, S. M.	Valparaiso	Porter	Richards, D. H.	Vincennes	Knox	Royer, E. Ray	North Salem	Hendricks
*Rafferty, Michael A.	Elkhart	Elkhart	Richards, E. E.	Russellville	Montgomery	Royster, George M.	Evansville	Vanderburgh
Ragsdale, H. C.	Bedford	Lawrence	*Richards, Norman F.	Shelbyville	Shelby	Royster, Hollace R.	Frankfort	Clinton
Rainey, E. A.	Lebanon	Boone	Richards, R. H.	Patricksburg	Owen	*Royster, R. A.	Evansville	Vanderburgh
*Ramage, W. F.	Fortville	Hancock	*Richardson, C. L.	Rochester	Fulton	*Rozelle, Clarence V.	Anderson	Madison
Ramsay, J. P. (H)	Vincennes	Knox	*Richart, J. V.	Terre Haute	Vigo	*Rubin, Gerald S.	Indianapolis	Marion
*Ramsey, Frank B.	Indianapolis	Marion	Richer, O. H.	Warsaw	Kosciusko	*Rubin, M. R.	Gary	Lake
*Ransey, H. S.	Bloomington	Monroe	*Richey, Clifford	Evansville	Vanderburgh	Rubin, Milton M.	Terre Haute	Vigo
*Randall, Karl C. II	La Fayette	Tippecanoe	Richter, Arthur B.	Indianapolis	Marion	Ruby, Fred McKeny	Union City	Randolph
Ranes, J. R.	Mount Vernon	Posey	Richter, Samuel	Gary	Lake	*Ruch, Monroe K.	Indianapolis	Marion
			Ricker, E. G.	Monticello	White	Ruddell, Karl R.	Indianapolis	Marion
			Ricketts, J. W.	Indianapolis	Marion	Ruddick, H. C.	Evansville	Vanderburgh
			Ridenour, David C. (II)	Peru	Miami	Rudesill, C. L.	Indianapolis	Marion
			Ridgeway, O. W.	Indianapolis	Marion	*Rudolph, Carl J.	South Bend	St. Joseph
			Rigg, J. F.	Indianapolis	Marion	Rudolph, F. G.	Hammond	Lake
			Riggs, Floyd	Terre Haute	Vigo			
			Rigley, E. L.	South Bend	St. Joseph			

Name	City	County	Name	City	County	Name	City	County
*Rudser, D. H.	Whiting	Lake	Schutt, J. B.	Ligonier	Noble	*Silverman, Norman M.	Terre Haute	Vigo
Ruhmkorff, Ralph H.	Goodland	Jasper-	*Schwartz, David I.	Fort Wayne	Allen	Silvers, J. C.	Muncie	Delaware-
		Newton	Schwartz, W. D.	Portland	Jay			Blackford
Runyan, H. C.	Alexandria	Madison	Schweitzer, Ada E.	Indianapolis	Marion	Silvers, J. M.	Muncie	Delaware-
Rupel, Ernest	Indianapolis	Marion	Scott, Frank M.	South Bend	St. Joseph			Blackford
Ruschli, E. B.	La Fayette	Tiptecanoe	Scott, G. D.	Sullivan	Sullivan	Silvian, Harry	Whiting	Lake
Rusk, Hubert M.	Wallace	Fountain-	*Scott, H. V.	Fort Wayne	Allen	Simmons, L. H.	Goshen	Elkhart
		Warren	Scott, Irvin H.	Sullivan	Sullivan	Simon, A. R.	La Porte	La Porte
*Russell, O. Raymond	Frankton	Madison	*Scott, I. W.	Indianapolis	Marion	Simon, A. V.	New Albany	Floyd
*Rust, Byron K.	Indianapolis	Marion	Scott, R. F.	Kokomo	Howard	Simons, J. S. (H)	Lyons	Greene
Ruth, Martin L.	Indianapolis	Marion	Scott, R. O.	Charlottesville	Hancock	Simpson, Morrell E.	Bedford	Lawrence
Rutherford, C. W.	Indianapolis	Marion	Scott, S. L.	Indianapolis	Marion	*Sims, J. Lawrence	Indianapolis	Marion
Ryan, H. J.	Gary	Lake	Scott, V. Brown	Shelbyville	Shelby	Sims, S. B. (H)	Frankfort	Clinton
Ryan, L. K.	Gary	Lake	Scudder, A. N.	Brownburg	Hendricks	Singer, E. C.	Fort Wayne	Allen
			Scudder, J. A.	Edwardsport	Knox	*Sink, Frank G.	Remington	Jasper-
*Sage, C. V.	Brownstown	Marion	*Seal, Perry F.	Indianapolis	Marion			Newton
Sage, Russell	Indianapolis	Marion	Seale, Joseph	Fairmount	Grant	*Sirlin, E. M.	Mishawaka	St. Joseph
Sagel, Jacob	Gary	Lake	*Seaman, C. F.	Indianapolis	Marion	Sisson, Helen M.	Pendleton	Madison
*Sala, J. J.	Gary	Lake	Sears, M. Maywood	Elkhart	Elkhart	Skeen, E. D.	Gary	Lake
*Salb, John A.	Indianapolis	Marion	Seaton, Albert	Indianapolis	Marion	Skillen, P. G.	South Bend	St. Joseph
Salb, Leo A.	Jasper	Dubois	Seaton, G. W.	Indianapolis	Marion	*Skobba, Joseph S.	Fort Wayne	Jennings
*Salb, Max C.	Indianapolis	Marion	*Sedam, Herbert L.	Indianapolis	Marion	Skomp, Claud E.	Marion	Grant
Salon, Harry W.	Fort Wayne	Allen	Segar, Louis H.	Indianapolis	Marion	Skrentny, Stanley	Hammond	Lake
Salon, N. L.	Fort Wayne	Allen	*Selby, K. E.	South Bend	St. Joseph	Slabaugh, J. S.	Nappanee	Elkhart
Samples, J. T.	Boonville	Warriek	Selsam, Etta B.	Terre Haute	Vigo	Slabaugh, Lotus M.	Nappanee	Elkhart
*Sanders, I. M.	Greensburg	Decatur	Senese, T. J.	Gary	Lake	*Slegelmilch, Lorin	Wabash	Wabash
Sanders, J. A.	Auburn	De Kalb	Sennett, C. M.	South Bend	St. Joseph	*Slick, C. R.	Lynn	Randolph
Sanderson, R. B.	South Bend	St. Joseph	*Sennett, Wm. K.	Winamac	Pulaski	Sloan, H. P.	New Albany	Floyd
*Sanderson, R. J.	Westville	La Porte	Sensenich, R. L.	South Bend	St. Joseph	*Slominski, H. H.	South Bend	St. Joseph
Sandock, Isadore	South Bend	St. Joseph	Senseny, Herbert	Fort Wayne	Allen	Sloss, I. H.	Terre Haute	Vigo
*Sandock, Louis	South Bend	St. Joseph	Sessions, S. K. (H)	Anna, Ill.	Marion	*Sluss, David H.	Indianapolis	Marion
Sandorf, M. H.	Indianapolis	Marion	*Seward, G. W.	N. Manchester	Wabash	Sluss, John W. (H)	Indianapolis	Marion
*Sandoz, Harry	South Bend	St. Joseph	Sesson, Hiram	Greenfield	Hancock	Small, E. F.	Vincennes	Knox
Sandoz, Louis A.	South Bend	St. Joseph	Seybert, J. D.	Kendallville	Noble	*Smallwood, R. B.	Bedford	Lawrence
*Sandy, Wm. A.	Indianapolis	Marion	Seyler, Anna G.	Crown Point	Lake	Smelser, H. W.	Connersville	Fayette-
Saunders, J. L.	Newport	Parke-	Shacklett, H. B.	New Albany	Floyd			Franklin
		Vermillion	Shafer, J. W.	La Fayette	Tiptecanoe	Smiley, J. H.	Indianapolis	Marion
*Savage, A. R.	Fort Wayne	Allen	Shafer, Marion R.	Indianapolis	Marion	*Smith, David J.	Indianapolis	Marion
Savery, C. E.	South Bend	St. Joseph	*Shaffer, K. L.	Vincennes	Knox	*Smith, D. L.	Indianapolis	Marion
Sayers, F. E.	Terre Haute	Vigo	Shallenberger, H. R.	Modoc	Randolph	*Smith, E. Rogers	Indianapolis	Marion
*Seales, A. B.	Oakland City	Gibson	*Shaniedling, Philip D.	Hammond	Lake	Smith, Francis C.	Indianapolis	Marion
Scamahorn, Malcolm O.	Pittsboro	Hendricks	Shanklin, E. M.	Hammond	Lake	Smith, G. A.	New Haven	Allen
Scamahorn, O. T.	Pittsboro	Hendricks	Shanklin, H. L.	Henryville	Clark	Smith, H. Brooks	Bluffton	Wells
Schaaf, Alvin	Jamestown	Boone	*Shanklin, James	Hammond	Lake	Smith, H. N.	Brookville	Fayette-
Schaefer, C. R.	Indianapolis	Marion	Shanklin, V. A.	Terre Haute	Vigo			Franklin
Schaible, E. L.	Gary	Lake	Shanks, Ray W.	Noblesville	Hamilton	*Smith, H. S.	Gary	Lake
*Schantz, Richard	Remington	Jasper-	Shanks, Roy E.	Rushville	Rush	Smith, James M.	Nashville	Marion
		Newton	*Sharp, John L.	Crawfordsville	Montgomery	Smith, James S.	Muncie	Delaware-
Schauwecker, Cleon M.	Greencastle	Putnam	*Sharp, W. L.	Anderson	Madison			Blackford
*Schechter, John S.	Indianapolis	Marion	Shattuck, John C.	Brazil	Clay	*Smith, John H.	Bloomington	Monroe
Scheetz, Marion R.	Lewisville	Henry	Shedd, H. B.	South Bend	St. Joseph	*Smith, Joseph S.	Plainfield	Hendricks
Scheier, E. W.	Indianapolis	Marion	*Sheehan, Francis G.	Indianapolis	Marion	*Smith, L. C.	La Fayette	Tiptecanoe
*Schellhouse, Earl M.	Fort Wayne	Allen	*Sheek, Kenneth I.	Greenwood	Johnson	Smith, L. W.	Warren	Huntington
Schenek, Foss	Fort Wayne	Cass	Shellhouse, Michael	Gary	Lake	Smith, Lester A.	Indianapolis	Marion
Schenk, G. H.	Ridgeville	Randolph	Shenk, E. M.	Kokomo	Howard	Smith, Louis D.	East Chicago	Lake
Scherer, Simon P. (H)	Martinsville	Morgan	Shepard, Fred F.	College Corner,	Wayne-	Smith, Paul B.	East Chicago	Lake
Scheurich, Virgil	Oxford	Benton		Ohio	Union	Smith, Paul E.	Richmond	Wayne-
Schick, Martin F. (H)	Fort Wayne	Allen	Sherster, Harry	Huntingburg	Dubois			Union
*Schiller, Herbert A.	South Bend	St. Joseph	Sherwood, J. Vincent	Fort Wayne	Allen	*Smith, R. A.	New Castle	Henry
Schlegel, Edward H.	Fort Wayne	Allen	*Shields, Jack E.	Ewing	Marion	Smith, R. D.	Bloomington	Monroe
Schlemmer, George H.	Warsaw	Kosciusko	Shimer, Wm.	Indianapolis	Marion	Smith, R. Lee	Osgood	Ripley
Schlesinger, Jacob	Hammond	Lake	Shinabery, Lawrence	Fort Wayne	Allen	*Smith, Roy L.	Indianapolis	Marion
Schlieker, A. G. (H)	East Chicago	Lake	Sholty, L. O.	La Fayette	Tiptecanoe	Smith, T. J.	Whiting	Lake
Schlosser, H. C.	Elkhart	Elkhart	*Sholty, W. M.	La Fayette	Tiptecanoe	Smith, W. E.	Decatur	Adams
Schmiedicke, P. H.	La Fayette	Tiptecanoe	Short, John	Fort Wayne	Allen	Smith, Wilbur F.	Wash., D. C.	Marion
*Schmitt, Richard K.	Columbus	Bartholomew	Shortridge, W. H.	Seymour	Jackson	*Smithson, Robert A.	Evansville	Vanderburgh
Schneider, A. J.	Indianapolis	Marion	*Shortz, Gerald	Kendallville	Noble	Smoot, E. Brayton	Washington	Daviess-
*Schneider, Carl J.	Indianapolis	Marion	Shoup, H. B.	Greentown	Howard			Martin
*Schneider, C. P.	Evansville	Vanderburgh	Showalter, John	Waterloo	De Kalb	Smoots, S. A.	Terre Haute	Vigo
Schoen, P. H.	New Albany	Floyd	*Shrader, Jack C.	Indianapolis	Marion	Smullen, Chas. L. (H)	Rushville	Rush
Schoofield, Wm. E.	Orleans	Orange	Shrock, E. E.	Amboy	Miami	*Smullen, Willard C.	Rushville	Rush
Schott, Edward J.	Terre Haute	Vigo	*Shuck, Wm. H.	Madison	Jefferson	Sneary, K. D.	Avilla	Noble
Schriefer, E. E.	Cannelton	Perry	*Shuler, L. L.	Indianapolis	Marion	Snider, Byron	Indianapolis	Marion
Schriefer, V. V.	Evansville	Vanderburgh	Shullenberger, W. A.	Indianapolis	Marion	Snyder, E. R.	Troy	Perry
Schulman, Gabriel	Indianapolis	Marion	*Shulruff, H. I.	Hammond	Lake	Solomon, R. A.	Indianapolis	Marion
Schuldt, T.	Piercetown	Kosciusko	Shultz, H. M.	Logansport	Cass	*Somers, G. H.	Fort Wayne	Allen
Schuler, R. P.	Kokomo	Howard	*Sicks, O. W.	Indianapolis	Marion	Somers, L. E.	Fort Wayne	Allen
*Schulhof, M. G.	Muncie	Delaware-	Siebenmorgen, Louis	Terre Haute	Vigo	Souder, Bonnell M.	Auburn	De Kalb
		Blackford	Siekerman, C. W.	Indianapolis	Marion	Sourwine, C. C.	Brazil	Clay
Schulz, C. H.	Lagrange	Lagrange	*Siekierski, J. M.	Gary	Lake	Souter, Martha C.	Indianapolis	Marion
Schulze, Hans A.	Cumberland	Marion	Siersdorfer, T. N.	Indianapolis	Marion	Southern, C. B.	Noblesville	Hamilton
Schulze, Wm.	Vincennes	Knox	*Siewert, O. L.	Logansport	Cass	*Sovine, Joe W.	Indianapolis	Marion
Schumaker, Eugene	Rensselaer	Jasper-	Sigmon, E. L. (H)	Floyd Knobs	Floyd	Spahr, D. E.	Portland	Jay
		Newton	Sigmund, Harvey W.	Indianapolis	Marion	Spahr, John F.	Indianapolis	Marion
Schumaker, Robert A.	Terre Haute	Vigo	*Sigmund, Wm. B.	Columbus	Bartholomew	*Spalding, J. J.	Indianapolis	Marion
Schuman, Edith B.	Bloomington	Monroe	*Silbert, David B.	Shelbyville	Shelby	*Spalding, W. L.	Mishawaka	St. Joseph
Schuman,	Columbia City	Whitley	Silliman, G. S.	Terre Haute	Vanderburgh	*Spangler, Jesse S.	Kokomo	Howard
Oliver V. (H)			Silverburg, S. G.	Evansville	Vanderburgh	Sparks, A. J.	Fort Wayne	Allen
						*Sparks, Alan L.	Indianapolis	Marion

Name	City	County	Name	City	County	Name	City	County
Sparks, Paul W.	Winchester	Randolph	Storer, Wm. R.	Hobart	Lake	*Tharpe, Ray	Indianapolis	Marion
*Spaulding, Earl	New Albany	Floyd	Storey, Joseph L.	Indianapolis	Marion	*Thatcher, H. K., Jr.	Indianapolis	Marion
Spears, John K.	Paoli	Orange	Stork, Harvey	Huntingburg	Dubois	*Thayer, B. W.	North Vernon	Jennings
*Speas, R. C.	Bloomington	Monroe	*Stork, Urban	Evansville	Vanderburgh	*Thimlar, J. Wiley	Fort Wayne	Allen
Spehger, Benjamin A.	Bedford	Lawrence	Storms, Roy B.	Indianapolis	Marion	*Thom, Jay W.	Gosport	Owen
Spencer, Frederic	Vincennes	Knox	Stottlemeyer, S. J.	Anderson	Madison	Thom, Julia S.	Spencer	Owen
Spencer, W. A.	Wolcott	Tippecanoe	Stouder, Albert E.	Kempton	Tipton	Thomas, C. B.	Plainfield	Hendricks
Spenner, R. W.	South Bend	St. Joseph	Stouder, C. E.	Gosport	Owen	Thomas, C. B.	Leesburg	Kosciusko
Spiehl, Wm. H.	Lebanon	Boone	*Stout, R. B.	Elkhart	Elkhart	*Thomas, Everett W.	Leesburg	Kosciusko
Spigler, James	Terre Haute	Vigo	*Stout, Walter M.	New Castle	Henry	Thomas, F. A.	Indianapolis	Marion
Spigler, O. R.	Terre Haute	Vigo	Stover, C. J.	Muncie	Delaware- Blackford	Thomas, G. A.	La Fayette	Tippecanoe
*Spindler, Robert	New Castle	Henry				*Thomas, Morris C.	Oaklandon	Marion
Spink, Urbana	Indianapolis	Marion				*Thomas, Morris E.	Indianapolis	Marion
Spinning, Alva (H)	Michigan City	Fountain- Warren	*Stover, W. C.	Boonville	Warrick	Thomas, Ray H.	South Bend	St. Joseph
			Stoyeff, C. M.	Gary	Lake	Thompson, A. A.	Tyner	Marshall
*Spivey, R. J.	Indianapolis	Marion	Strange, Martin B.	New Albany	Floyd	*Thompson, Chas. F.	Indianapolis	Marion
Spolyar, L. W.	Indianapolis	Marion	Strange, J. W.	Loogootee	Daviess- Martin	Thompson, J. V.	Indianapolis	Marion
Sponder, Joseph	Gary	Lake				*Thompson, John M.	Bremen	Marshall
Springstun, C. E.	Tennysen	Warrick	Straughn, Walter L.	Crawfordsville	Montgomery	Thompson, Lewis	New Harmony	Posey
Springstun, C. L.	Chrisney	Spencer	Strayer, J. W.	La Fayette	Tippecanoe	*Thompson, Paul V.	Indianapolis	Marion
Springstun, George	Oaktown	Knox	Streck, F. A.	Lawrenceburg	Dearborn- Ohio	Thompson, W. A.	Liberty	Wayne- Union
*Springstun, W. R.	Evansville	Vanderburgh				Thompson, W. N. (H)	Sullivan	Sullivan
Spurgeon, O. E.	Muncie	Delaware- Blackford	Streib, Homer F.	Redkey	Jay	Thomson, J. W.	Garrett	De Kalb
			Strickland, Karl S.	Owensville	Gibson	*Thornburg, Kenneth	Indianapolis	Marion
Spurlock, Fae H.	Cleveland, Ohio	Marion	Strong, Daniel S.	Terre Haute	Vigo	*Thorne, C. E.	New Castle	Henry
Spath, Carl B.	Indianapolis	Marion	*Stroup, Tyler J.	Indianapolis	Marion	Thornton, Harold C.	Indianapolis	Marion
Spath, Carl B., Jr.	Indianapolis	Marion	Stuekman, E. D.	New Paris	Elkhart	Thornton, Maurice J.	South Bend	St. Joseph
*Staff, R. A.	Rockville	Parke- Vermillion	Study, Joseph N. (H)	Cambridge City	Wayne- Union	Thornton, Walter	Fort Wayne	Allen
			Stultz, Q. F.	Ligonier	Noble	Thrasher, John R.	Indianapolis	Marion
Stafford, J. C.	Plainfield	Hendricks	Stygall, J. H.	Indianapolis	Marion	Thurston, A. L.	Indianapolis	Marion
*Stafford, W. C.	Plainfield	Hendricks	*Sudranski, Herbert F.	Indianapolis	Marion	Thurston, H. F.	Indianapolis	Marion
Stahl, Edward	La Fayette	Tippecanoe	Sullenger, A. A.	Indianapolis	Marion	Thurston, H. S.	Indianapolis	Marion
Stalker, James B.	Indianapolis	Marion	*Sullivan, John M.	Terre Haute	Vigo	Tiley, George	Greenwood	Johnson
*Stamper, J. H.	Middletown	Henry	Sullivan, T. L.	Indianapolis	Marion	Tindal, E. F.	Muncie	Delaware- Blackford
*Stamper, L. Allen	Richmond	Wayne- Union	Sutter, Charles C.	Evansville	Vanderburgh			
			*Sutton, Wm. E.	Edinburg	Johnson	Tindall, Paul R.	Shelbyville	Shelby
*Stangle, W. J.	Mooreville	Morgan	Suwerkup, Lotta A.	Columbus	Bartholomew	*Tindall, Wm. R.	Shelbyville	Shelby
*Stanley, J. S.	East Chicago	Lake	Swan, John R.	Indianapolis	Marion	Tinney, W. E.	Indianapolis	Marion
Stanton, J. J.	Logansport	Cass	Swan, Richard Carl	Indianapolis	Marion	Tinsley, W. B.	Indianapolis	Marion
Stauffer, Walter A.	Elkhart	Elkhart	Swank, L. Forest	Elkhart	Elkhart	*Tipton, Wm. R.	Greencastle	Putnam
Stayton, C. A.	Indianapolis	Marion	Swanson, John	Fort Wayne	Allen	Tirico, J. G.	Hammond	Lake
*Stayton, Chester A., Jr	Indianapolis	Marion	Swantuseh, O. H.	Angola	Steuben	*Tischer, E. P.	Indianapolis	Marion
*Stee, Peter	Whiting	Lake	Swarts, Willard W.	Auburn	De Kalb	Titus, Charles	Wilkinson	Hancock
*Steele, Brandt F.	Indianapolis	Marion	Swayne, J. F.	Indianapolis	Marion	Titus, Philip S.	Fort Wayne	Allen
*Steele, D. J.	Greencastle	Putnam	Sweet, Austin D.	Martinsville	Morgan	Todd, D. D.	Elkhart	Elkhart
Steele, E. B.	Crown Point	Lake	*Sweet, Howard E.	Richmond	Wayne- Union	Tomak, M. E.	Linton	Greene
Steffen, A. J.	Wabash	Wabash				Tomlinson, C. H.	Cicero	Hamilton
Steffen, J. T.	Wabash	Wabash	Swezey, H. N.	La Fayette	Tippecanoe	*Topolugus, James N.	Bloomington	Monroe
Steinkamp, E. F.	Huntingburg	Dubois	Swihart, Glen L.	Lakeland, Fla.	Elkhart	Topping, M. C.	Terre Haute	Vigo
Steinman, H. E.	Monroeville	Allen	Swihart, L. F.	Elkhart	Elkhart	*Torrella, J. A.	Indianapolis	Marion
*Stellner, Howard A.	Pendleton	Madison	*Switzer, Robert E.	Cromwell	Noble	Totten, E. C.	Madison	Jefferson
Stemm, W. H. (H)	North Vernon	Jennings	*Szabo, S. A.	East Chicago	Lake	Tower, Thomas K.	Campbellsburg	Washington
Stephens, K. H.	Indianapolis	Marion				Tracy, J. Ross	Anderson	Madison
*Stephens, Lowell R.	Covington	Fountain- Warren	Take, J. F.	Valparaiso	Porter	Tranter, W. F.	Sharpville	Tipton
			*Talbot, Dan E.	Indianapolis	Marion	*Traver, P. C.	South Bend	St. Joseph
Stephens, R. Clarence (H)	Plymouth	Marshall	Tallman, H. H.	Culver	Marshall	*Travis, J. C., Jr.	Indianapolis	Marion
			Tate, W. W.	Thayer	Newton	Travis, Mary Francis	Lafayette	Tippecanoe
Stephenson, L. E.	Michigan City	La Porte	Tavener, Fred	Gas City	Grant	Tremain, M. A.	Adams	Decatur
*Stern, David H.	Hammond	Lake	*Taylor, C. C.	Indianapolis	Marion	Treon, James F.	Aurora	Dearborn- Ohio
Stern, Nathan	Indianapolis	Marion	Taylor, D. E.	Velpen	Pike			
Stern, S. L.	Hammond	Lake	Taylor, E. C.	Upland	Grant	Tripp, H. D.	Winston-Salem, N. C.	Adams
Stevens, George C.	Seattle, Wash.	Marion	*Taylor, F. W.	Indianapolis	Marion			
*Stevens, S. L.	Indianapolis	Marion	Taylor, J. E.	Leopold	Perry	*Trout, C. J.	Lafayette	Tippecanoe
Stewart, C. E.	Vincennes	Knox	Taylor, L. S.	Elberfield	Warrick	Troutwine, William R.	Crown Point	Lake
Stewart, Chas. S. (H)	Auburn	De Kalb	Taylor, R. D.	Indianapolis	Marion	Trusler, H. M.	Indianapolis	Marion
Stewart, F. C.	Staten Island, N. Y.	Vanderburgh	Taylor, W. H.	Ambia	Benton	Tubbs, George R.	La Fayette	Tippecanoe
			Taylor, W. M.	Crawfordsville	Montgomery	Tucker, C. C.	Greencastle	Putnam
*Stewart, J. H.	Marion	Grant	Taylor, W. R.	Richmond	Wayne- Union	Tucker, Jesse E.	Lebanon	Boone
Stewart, Milton B.	Logansport	Cass				Tucker, O. A.	Daleville	Delaware- Blackford
Stewart, O. H.	Aurora	Dearborn- Ohio	Teaford, S. F.	Paoli	Orange			
			Teague, Frank	Indianapolis	Marion	Tucker, Warren S.	Indianapolis	Marion
Stewart, Oscar H. (H)	Orleans	Orange	Teal, Dorothy D.	Columbus	Bartholomew	Fully, J. A.	New Castle	Henry
Stewart, W. E.	Terre Haute	Vigo	Teegarden, J. A., Jr.	East Chicago	Lake	Turley, Verne L.	Fowler	Benton
*Stier, Paul L.	Fort Wayne	Allen	Teegarden, J. A., Sr.	East Chicago	Lake	Turner, H. B.	Bloomfield	Greene
Stimson, Harry R.	Gary	Allen	Teeter, E. J.	Indianapolis	Marion	Turner, Oscar A.	Madison	Jefferson
Stinson, A. E.	Rocheater	Fulton	Teixler, V. A.	Indianapolis	Marion	Turner, Robert	Muncie	Delaware- Blackford
Stinson, Dean K.	Rocheater	Fulton						
*Stirling, E. H.	Fort Harrison	Marion	Templin, D. B.	Gary	Lake			
*Silver, Daniel	South Bend	St. Joseph	Tennant, David L.	Fort Wayne	Allen	*Tweedall, D. C.	Evansville	Vanderburgh
Stocking, B. W.	Muncie	Delaware- Blackford	Tennant, L. W.	Larwill	Whitley	Tweedall, D. G.	Evansville	Vanderburgh
			Tennis, George	Putnamville	Putnam	Tyler, F. T.	New Albany	Floyd
*Stoeffler, Walter	Indianapolis	Marion	*Teplinsky, L. L.	East Chicago	Lake	Tyrrell, Thomas C.	Hammond	Lake
*Stoefling, V. K.	Winchester	Randolph	Terflinger, F. W.	Logansport	Cass			
*Stoen, H. J.	La Fayette	Tippecanoe	Terhune, Rufus W. (H)	Martinsville	Morgan	Underwood, G. B.	Evansville	Vanderburgh
Stoler, A. E.	Fort Wayne	Allen	*Terrill, R. W.	Fort Wayne	Allen	*Urshel, Dan L.	Mentone	Kosciusko
*Stone, A. T.	Indianapolis	Marion	*Terry, C. C.	South Bend	St. Joseph	Utterback, Arnold	Terre Haute	Vigo
Stone, Charles E.	Bedford	Lawrence	Teter, Eber	Portland, Oreg.	Henry			
*Stone, David F.	Indianapolis	Marion	Teters, Melvin	Middlebury	Elkhart	Valentine, E. J.	Shelbyville	Shelby
*Stone, Wayne B.	Carmel	Hamilton	Tether, Joseph E., Jr.	Indianapolis	Marion	*Van Arsdall, C. R.	Terre Haute	Vigo

Name	City	County	Name	City	County	Name	City	County
Van Bokkelen, Robert	Mooresville	Morgan	*Washburn, W. W.	La Fayette	Tippecanoe	Williams, Charles D.	Indianapolis	Marion
VanBuskirk, E. L.	La Fayette	Tippecanoe	*Watson, Herman L.	Evansville	Vanderburgh	Williams, C. L.	Logansport	Cass
Van Buskirk, E. M.	Fort Wayne	Allen	Watts, A. A.	Gary	Lake	*Williams, Everett W.	Columbus	Bartholomew
Vance, Walter H.	Fort Wayne	Allen	Waymire, E. S.	Indianapolis	Marion	*Williams, F. M., Jr.	Pendleton	Madison
*Vance, Wm. C.	Richmond	Wayne-Union	Weaver, T. M.	Brazil	Clay	*Williams, F. P.	Huntingburg	Dubois
Vanderbogart, H. E.	Goshen	Elkhart	*Weaver, Wm. W.	New Albany	Floyd	Williams, George T. (H)	Crawfordsville	Montgomery
Vandevent, Arthur	Sellersburg	Clark	Webb, John W.	Indianapolis	Marion	Williams, H. O.	Kendallville	Noble
Vandivier, H. R.	Terre Haute	Vigo	Weber, Edgar H.	Evansville	Vanderburgh	Williams, John H.	Muncie	Delaware-Blackford
Vandivier, R. M.	Indianapolis	Marion	Weber, Robert C.	Indianapolis	Marion	Williams, Luther	Indianapolis	Marion
*Van Dorf, Nathaniel	East Chicago	Lake	Webster, R. K.	Brazil	Clay	Williams, Paul	Richmond	Wayne-Union
Van Kirk, George H.	Kentland	Jasper-Newton	Weddle, Chas. O.	Lebanon	Boone			
Van Kirk, J. A.	Frankfort	Clinton	Weed, Lyle A.	Indianapolis	Marion			
Van Nest, W. A.	Ashley	De Kalb	Weeks, P. H.	Michigan City	La Porte			
Van Nuys, W. C.	New Castle	Henry	*Weems, M. P.	Jeffersonville	Clark	*Williams, R. H.	Anderson	Madison
Van Osdol, H. A.	Indianapolis	Marion	Wegner, W. G.	South Bend	St. Joseph	*Willis, Charles F.	Evansville	Vanderburgh
Van Reed, Earl	La Fayette	Tippecanoe	Wehrman, J. O.	Indianapolis	Marion	Willis, Joseph H.	Evansville	Vanderburgh
Van Rie, L. P.	Mishawaka	St. Joseph	*Weigand, C. G.	Indianapolis	Marion	Willison, George	Evansville	Vanderburgh
Van Sandt, F. A.	Bloomfield	Greene	Weil, H. J.	Indianapolis	Marion	Willson, C. L.	Anderson	Madison
Van Sandt, J. W.	Carbon	Clay	Weinberg, Samuel	Marion	Grant	*Wilson, F. M.	Kokomo	Howard
Van Winkle, Arthur J.	Valparaiso	Porter	Weinstein, E. B.	Richmond	Wayne-Union	*Wilson, Fred	Terre Haute	Vigo
Varble, Wm. M.	Jeffersonville	Clark				Wilson, Guy	Bicknell	Knox
Varner, Victor I.	Evansville	Vanderburgh	Weinstein, J. H.	Terre Haute	Vigo	Wilson, J. L.	South Bend	St. Joseph
Veach, Lester W.	Bainbridge	Putnam	Weirich, Charles	Butler	De Kalb	Wilson, J. P.	Scottsburg	Scott
Veazey, Wm. (H)	Avilla	Noble	Weis, William D.	Crown Point	Lake	Wilson, J. R.	Terre Haute	Vigo
Velkoff, Metodi	Fort Wayne	Allen	*Weiss, Eugene	South Bend	St. Joseph	Wilson, L. A.	Michigan City	La Porte
*Venis, Kemper N.	Muncie	Delaware-Blackford	Weiss, H. G.	Evansville	Vanderburgh	*Wilson, Leslie	Fort Wayne	Allen
Verplank, G. L.	Gary	Lake	Weiss, Jason	Indianapolis	Marion	Wilson, O. E.	Elkhart	Elkhart
*Vetter, K. W.	Elkhart	Elkhart	*Weissman, Irving	Fort Wayne	Allen	*Wilson, O. R.	Shelbyville	Shelby
Viehe, Robert W.	Evansville	Vanderburgh	Welborn, J. Y.	Evansville	Vanderburgh	Wilson, Paul	Boonville	Warriek
Vietzke, P. C. F.	Valparaiso	Porter	Welborn, Mel B.	Evansville	Vanderburgh	Wilson, P. H.	Logansport	Cass
Viney, Charles L.	Logansport	Cass	*Weldy, B. P.	Hartford City	Delaware-Blackford	Wilson, R. C.	Franklin	Johnson
Visher, John W.	Evansville	Vanderburgh	Weller, Charles A.	Indianapolis	Marion	Wilson, Ralph	Evansville	Vanderburgh
Vlaskamp, Elaine	Muncie	Delaware-Blackford	Wells, Milo C.	Anderson	Madison	Wilson, Ralph	Shirley	Henry
			Welty, S. G.	Fort Wayne	Allen	Wilson, T. L.	Bloomington	Monroe
			Werry, L. E.	Hartford City	Delaware-Blackford	Wilson, W. L. (H)	Scipio	Jennings
						Wiltshire, James W.	Bloomington	Monroe
						Wimmer, G. G.	Huntington	Huntington
Vogel, L. John	Mt. Vernon	Posey	Wesson, Thomas W.	Evansville	Vanderburgh	Wimmer, Robert N.	Gary	Lake
*Voges, Edward C.	Terre Haute	Vigo	*West, Joseph L.	Indianapolis	Marion	*Winebreuner, J. D.	Columbus	Bartholomew
Voisinet, R. A.	Union City	Randolph	Westhafer, E. K.	New Castle	Henry	Withstandley, W. C.	New Albany	Floyd
Vollrath, V. J.	Shelbyville	Marion	Westra, J. J.	Evansville	Vanderburgh	Winters, Matthew	Indianapolis	Marion
Vore, Hugh A.	East Chicago	Lake	Weyerbacher, A. F.	Indianapolis	Marion	Wisch, L. J.	Whiting	Lake
Vore, L. W.	Plymouth	Marshall	Whallon, Arthur J.	Richmond	Wayne-Union	Wise, Charles	Camden	Carroll
Voyles, C. F.	Indianapolis	Marion				Wise, Wm.	Indianapolis	Marion
Voyles, Harry	New Albany	Floyd	Wharton, R. O.	Gary	Lake	Wiseheart, Oscar H.	North Salem	Hendricks
*Vracin, Daniel	Griffith	Lake	Wheeler, Homer H.	Indianapolis	Marion	Wisehart, Wm. (H)	Colfax	Clinton
Vye, James P.	Gary	Lake	Wheeler, J. T. (H)	Indianapolis	Marion	*Wiseheart, Robert	Lebanon	Boone
			Whipps, Charles E.	Carlisle	Sullivan	Wiseman, V. Earl	Greencastle	Putnam
			Whisler, F. M.	Wabash	Wabash	Wisener, G. H.	Richmond	Wayne-Union
			White, C. M.	Clinton	Parke-Vermillion			
						Wishard, F. B.	Pendleton	Madison
Wade, A. A.	Howe	Lagrange	White, C. S.	Rosedale	Parke-Vermillion	Wishard, Wm. N., Jr.	Indianapolis	Marion
Wadsworth, H. C.	Washington	Martin				Wishart, S. W.	Evansville	Vanderburgh
Wagner, S. C.	Elkhart	Elkhart	White, Claude H.	Mooresville	Morgan	*Witkowski, L. J.	La Porte	La Porte
*Wagoner, G. W.	Burrows	Carroll	White, Donald J.	Indianapolis	Marion	*Wolfram, Don J.	Indianapolis	Marion
Wagoner, Robert H.	Colburn	Tippecanoe	*White, Harvey E.	Martinsville	Morgan	Wolfstein, Isabel J.	Indianapolis	Marion
Waldo, J. Thayer	Indianapolis	Marion	White, I. D.	Clinton	Parke-Vermillion	*Woner, John W.	Linton	Greene
Wales, E. De Wolfe	Indianapolis	Marion				Wood, Amelia T.	Muncie	Delaware-Blackford
Walker, F. C.	Indianapolis	Marion	*White, James V.	Terre Haute	Vigo	Wood, Charles	Westport	Decatur
Walker, J. L.	La Fontaine	Wabash	White, W. J.	Gary	Lake	*Wood, Donald E.	Indianapolis	Marion
*Walker, Robert K.	Indianapolis	Marion	Whitehead, John M.	Indianapolis	Marion	Wood, E. U.	Columbus	Bartholomew
Walkinshaw, Wm. (H)	Stillwell	La Porte	*Whitlatch, Arthur	Milan	Ripley	Wood, George	Indianapolis	Marion
Wall, Joseph A.	Wabash	Wabash	Whitlatch, Bine	Milan	Ripley	*Wood, O. L.	Brazil	Clay
Wallace, E. R.	Aurora	Dearborn-Ohio	Whitlatch, I. A.	Milan	Ripley	*Wood, R. W.	Oakland City	Gibson
			*Whitlock, Merle E.	Mishawaka	St. Joseph	Wood, W. B.	Oakland City	Gibson
*Wallace, Hawthorne C.	Crawfordsville	Montgomery	Whitsitt, S. A.	Madison	Jefferson	*Wood, W. H.	Evansville	Vanderburgh
Wallace, J. C.	Fort Wayne	Allen	Whitten, Kathryn	Fort Wayne	Allen	Woodard, Abram S., Jr.	Indianapolis	Marion
Wallier, John I.	Knightsstown	Henry	Wickens, Mary	Richmond	Wayne-Union	Woodcock, C. E.	Greenwood	Johnson
Waller, W. F.	Angola	Steuken				Wooden, Edward I. (H)	Rushville	Rush
*Walsh, E. N.	Whiting	Lake	Wicks, O. C.	Gary	Lake	Woods, A. L.	Poseyville	Posey
*Walsh, T. P.	Garrett	De Kalb	Wiedemann, F. E.	Terre Haute	Vigo	*Woods, H. C.	Markle	Huntington
Walterhouse, H. K.	Ladoga	Montgomery	Wiggins, D. S.	New Castle	Henry	*Woods, James R.	Greenfield	Hancock
Walters, L. O.	Muncie	Delaware-Blackford	Wiggins, George	New Castle	Henry	Woods, W. P.	Evansville	Vanderburgh
Wanninger, Horace	Richmond	Wayne-Union	Wilber, H. R.	Jeffersonville	Clark	Woods, Wm. V.	Indianapolis	Marion
Ward, H. H.	Coalmont	Clay	Wilcox, R. F.	La Porte	La Porte	Wooldridge, Omer	Kokomo	Howard
*Ward, J. W.	Mishawaka	St. Joseph	Wilder, G. B.	Anderson	Madison	*Wooley, R. H.	Indianapolis	Marion
Ward, Wesley C.	Indianapolis	Marion	Wildman, R. E.	Peru	Miami	*Work, Bruce A.	Frankfort	Clinton
*Ware, J. R.	Andrews	Huntington	Wilhelm, Agatha M.	South Bend	St. Joseph	Work, James A.	Elkhart	Elkhart
*Warfel, F. C.	Indianapolis	Marion	Wilhelmus, Charles M.	Newburgh	Warrick	Workman, W. S. (H)	Mitchell	Orange
Warman, A. P.	Indianapolis	Marion	Wilhelmus, Wm. M.	Evansville	Vanderburgh	Worley, A. C.	Fort Wayne	Allen
Warne, G. H.	Tipton	Tipton	*Wilkins, I. W.	Indianapolis	Marion	*Worley, J. P.	Indianapolis	Marion
Warren, Frank R.	Michigan City	La Porte	Wilkin, W. Ernest	South Whitley	Whitley	Worth, C. W.	Milroy	Rush
*Warren, John C.	Bicknell	Knox	*Wilkins, R. W.	Fort Wayne	Allen	Wray, C. M.	La Fayette	Tippecanoe
*Warner, James B.	Indianapolis	Marion	Willan, H. R.	Martinsville	Morgan	Wright, Cecil S.	Anderson	Madison
Warvel, J. H.	Indianapolis	Marion	*Willett, I. H.	Fort Wayne	Allen	Wright, E. D.	Seymour	Jackson
Warvel, J. L. (H)	N. Manchester	Wabash	*Williams, A. H.	Fort Wayne	Allen			
*Washburn, Richard N.	Reusselaer	Jasper-Newton	Williams, Bernice M.	New Haven	Allen			

Name	City	County	Name	City	County	Name	City	County
Wright, J. William	Indianapolis	Marion	Yeck, C. W.	Evansville	Vanderburgh	Yung, J. Rudolph	Terre Haute	Vigo
Wright, W. C.	Fort Wayne	Allen	*Yegerlehner, Roscoe	Kentland	Jasper-	*Yunker, P. E.	Evansville	Vanderburgh
Wright, W. W.	New Castle	Henry			Newton			
Wurster, H. C.	Mishawaka	St. Joseph	Yeneer, M. W.	Richmond	Wayne-	Zallen, S. G.	East Chicago	Lake
Wyatt, Fred H.	Evansville	Vanderburgh			Union	*Zaring, B. K.	Columbus	Bartholomew
Wyatt, James L.	Fort Wayne	Allen	Yocum, Boaz (H)	Coal City	Owen	Zehr, Noah	Fort Wayne	Allen
Wyatt, James L. III	Fort Wayne	Allen	Yocum, P. S.	Gary	Lake	Zerfas, L. G.	Merom	Sullivan
Wybourn, R. C.	Ossian	Wells	Yoder, Albert C.	Goshen	Elkhart	Zierer, R. O.	Anderson	Madison
Wyth, Charles	Terre Haute	Vigo	Yoder, D. D.	Columbus	Bartholomew	*Zimmer, Henry J.	Mishawaka	St. Joseph
Wygant, M. D.	Mishawaka	St. Joseph	*Yoman, Tom	La Fayette	Tippecanoe	Zimmerman, Harold	Evansville	Vanderburgh
Wyland, B. J.	Mishawaka	St. Joseph	Young, E. M.	Sheridan	Hamilton	Zimmerman, R. G.	Berne	Adams
Wynn, J. F.	Evansville	Vanderburgh	Young, G. M.	Gary	Lake	Zivich, J. M.	East Chicago	Lake
Wynne, R. E.	Bedford	Lawrence	*Young, G. S.	Muncie	Delaware-	*Zweig, E. S.	Fort Wayne	Allen
Wyttenbach, Frederick	Indianapolis	Marion			Blackford	*Zwerner, Paul F.	Terre Haute	Vigo
*Wyttenbach, John E.	Indianapolis	Marion	*Young, John M.	Indianapolis	Marion	*Zwick, Harold	Decatur	Adams
			Young, Ralph H.	Goshen	Elkhart	*Zwickel, R. E.	Newburgh	Warriek
			Young, S. J. (H)	Kendallville	Noble			
Yarling, J. E. (H)	Peru	Miami	*Young, W. C.	Indianapolis	Marion			
Yarrington, C. W.	Gary	Lake						

ABSTRACTS

CIGARET ASH

In answer to the question of "How harmful is cigaret tobacco ash, for example, when it is accidentally spilled on food and the food accidentally eaten?" *The Journal of the American Medical Association* for September 30 says:

"The ash of cigaret tobacco itself may contain traces of lead or arsenic, as well as carbon and mineral constituents, but in itself it is not harmful when ingested in small amounts. However, the incompletely burned cigaret tobacco behind the burning point may contain rather high concentrations of tobacco alkaloids, and so care should be taken to avoid contamination of food with material from the stump, behind the ash. Nicotine poisoning, with fatalities, has been reported from contamination of food with cigaret residues, but it is the unburned material, not the ash, which is here responsible."

SMALL DOSES OF SULFONAMIDES SHORTEN COURSE OF TONSILLITIS

The administration of small doses of sulfonamides appreciably shortens the course of tonsillitis and minimizes the complication of peritonsillar abscess, thus saving thousands of man-days to industry and the armed forces, Captain Edward D. Freis, Medical Corps, Army of the United States, reports in *The Journal of the American Medical Association* for September 9.

Captain Freis' report is based on controlled studies of a series of 405 young men of military age who had definite clinical evidence of acute follicular tonsillitis and were hospitalized in a separate ward devoted to their care. They were divided into four groups. The first group, consisting of 100 patients, were given only hot saline irrigations every four hours and received no sulfonamide treatment. Another group of 100 patients were treated with hot saline irrigations every four hours and in addition received sulfanilamide spray to the tonsils and pharynx every two hours except while asleep. A third group, consisting of 115 patients, received saline irrigations every four hours and, in addition, sulfadiazine tablets (125 mg.) by mouth four times a day. The fourth group of 90 patients were treated in the same way as the second group except that microform (minute) crystals of sulfadiazine were substituted for sulfanilamide powder.

Whereas it took an average of 4.7 days for clinical recovery of those in Group 1 (who did not receive

sulfonamides) the average in Group 2 was 3.5 days. In Group 3 it was 3.6 days and in Group 4 it was 3.0 days. There were no toxic or sensitization reactions observed in any of the 305 patients who received sulfonamides.

The small difference between the groups receiving sulfadiazine and the one receiving sulfanilamide, Captain Freis explains, "can be attributed to the well-known fact that sulfadiazine is more effective in infections caused by the hemolytic streptococcus than is sulfanilamide."

"The fact that the patients in Group 3, who received 0.5 gm. of sulfadiazine daily in tablet form, showed a rate of recovery comparable to the groups receiving local spray raises the question of the advisability of using topical therapy in the treatment of tonsillitis. As tablets are more easily administered than local spray, there is no clinical reason for the use of the latter in the treatment of this condition. . . ."

In the group receiving no sulfonamides, six cases of peritonsillar abscess developed as a complication during the period of hospitalization whereas only two cases developed in the sulfonamide groups, one among the sulfanilamide spray-treated patients and one among those receiving sulfadiazine tablets.

The temperature returned to normal in an average of 3.3 days among the patients who did not receive sulfonamide treatment whereas in Group 2 the average was 2.3 days; in Group 3 it was 1.6 days and in Group 4 it was 1.4 days.

"The saving of even one day in hospitalization has much economic and military importance," Captain Freis points out, "since, when the incidence of tonsillitis is considered, this saving can be translated into terms of thousands of man-days salvaged. In view of the fact that the patients receiving sulfonamides experienced subjective relief even though some residual signs of subsiding inflammation remained, it is possible that such patients can be discharged to military duty or to industry as soon as the temperature becomes normal, with the stipulation that they continue to take small doses of sulfadiazine for several days thereafter. A further saving of time would thereby result."

"It is possible that the use of more than 500 mg. of sulfadiazine daily would have further hastened recovery. However, when dealing with a potentially harmful drug, a balance must be struck between effective and toxic dosage. The complete absence of sulfonamide reactions in the treated groups favors the use of small dosage in the treatment of tonsillitis. This does not imply that these small doses of sulfonamides necessarily are effective in other infections."

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

HOUSE OF DELEGATES

Special Meeting—Indianapolis Athletic Club
November 12, 1944

A special meeting of the House of Delegates was held at the Indianapolis Athletic Club, Indianapolis, on Sunday, November 12, 1944; the president, Dr. J. T. Oliphant, of Farmersburg, presiding.

DR. OLIPHANT: It is about ten o'clock; we are a little behind time. It is time to open this meeting, and I wish you would all move forward into these seats closer up.

It is very gratifying to see so many delegates here. As you understand, this meeting is a called special meeting of the House of Delegates, and was authorized by the last meeting of the House of Delegates, on October 5, for the purpose of discussing the report of the Reference Committee on the report of the Permanent Study Committee on Health Insurance. We will now have Dr. Weyerbacher call the roll of the delegates.

DELEGATES

County	Delegates	Response
Adams	Gerald J. Kohn	
Allen	William Wright	Here
	M. R. Lohman	Here
	M. B. Catlett	Here
Bartholomew	Joseph E. Dudding	Here
	H. H. Kamman (Alt.)	Here
Benton	V. L. Turley	Here
Boone	A. D. Schaaf	Here
Carroll	Max R. Adams	Here
Cass	B. W. Egan	Here
Clark	E. P. Buckley	Here
Clay	J. F. Maurer	Here
Clinton	F. A. Beardsley	Here
Crawford	J. J. Johnson	
Daviess-Martin	C. P. Fox	Here
Dearborn-Ohio	G. S. Fessler	Here
	C. F. Fletcher	Here
Decatur	I. M. Sanders	
DeKalb	John Showalter	
Delaware-Blackford	Clay A. Ball	Here
	B. W. Stocking	Here
Dubois	Paul J. Blessinger	Here
Elkhart	A. C. Yoder	Here
Fayette-Franklin	E. M. Glaser	Here
	H. N. Smith	Here
Floyd	G. Irene Polhemus	Here
Fountain-Warren	J. Carl Freed	
Fulton	A. E. Stinson	Here
Gibson	Carl Clark	Here
Grant	Russell Lavengood	Here
Greene		
Hamilton	C. M. Donahue	Here
Hancock	J. E. Ferrell	Here
Harrison	William E. Amy	Here
Hendricks	O. T. Seamahorn	Here
Henry		
Howard	E. R. Clarke	Here
	Thomas M. Conley (Alt.)	Here
Huntington	G. M. Nie	Here

County	Delegates	Response
Jackson	Harry English	
Jasper-Newton	R. H. Ruhmkorff	
	G. V. Cring	Here
Jay		
Jefferson	D. W. Matthews	Here
Jennings	O. A. Province	
Johnson	C. L. Boyd	Here
Knox		
Kosciusko	W. O. Hildebrand	
LaGrange	G. L. Verplank	Here
Lake	P. Q. Row	Here
	H. W. Eggers	
	C. R. Pettibone	Here
	C. M. Jones	Here
LaPorte	Jon Kelly	Here
Lawrence	Claude Dollens	Here
Madison	A. W. Elsten	Here
	C. S. Wright	
	A. T. Jones	Here
Marion	George J. Garceau	Here
	Ben B. Moore	Here
	Roy V. Myers	Here
	Goethe Link	
	O. H. Bakemeier	Here
	William N. Wishard, Jr.	
	Harold Ochsner	Here
	Russell Sage	
	Ernest Rupel	Here
	Rollin Moser	Here
	Walter Morton	Here
	J. O. Ritchey	Here
	Marlow Manion	Here
	E. Vernon Hahn	Here
	J. E. Dalton	Here
	R. E. Mitchell	Here
	W. D. Gatch	Here

Anybody here of the alternates acting for Marion County?

County	Delegates	Response
Marshall	A. A. Thompson	Here
Miami	F. M. Lynn	
Monroe	Naomi Dalton	Here
	H. S. Hepner (Alt.)	Here
Montgomery	G. A. Collett	Here
Morgan		
Noble	A. L. Fipp	
Orange	C. E. Boyd	Here
Owen		
Parke-Vermillion	Paul B. Casebeer	Here
Perry		
Pike	J. T. Kime	
Porter	John R. Frank	Here
	John F. Take (Alt.)	Here
Posey	J. R. Ranes	Here
Pulaski		
Putnam	V. Earle Wiseman	Here
Randolph	W. S. Dininger	Here
Ripley	R. Lee Smith	Here
Rush	C. C. Atkins	Here
St. Joseph	A. S. Giordano	Here
	Morris Balla	Here
	F. R. N. Carter	Here
Scott		
Shelby	W. D. Inlow	Here
Spencer		
Starke		
Steuben		
Sullivan	J. R. Crowder	Here
Switzerland		

County	Delegates	Response	
Tippecanoe	Earl Van Reed	Here	B. N. Lingeman, Montgomery County
	Gordon A. Thomas	Here	H. E. Klepinger, Tippecanoe County
Tipton	S. M. Cotton		H. B. Annis, Wells County
Vanderburgh	Robert R. Acre	Here	Guy W. Spring, Blue Cross Hospital Service
	Minor Miller	Here	
	James Y. Welborn	Here	
Vigo	E. O. Nay	Here	
	M. C. Topping	Here	
Wabash	O. G. Brubaker	Here	
Warrick			
Washington	Claude B. Paynter		
Wayne-Union	H. P. Ross	Here	
	W. A. Thompson	Here	
Wells	Robert Wybourn	Here	
	H. Brooks Smith (Alt.)	Here	
White	H. B. Gable		
Whitley	Paul M. Garber		

COUNCILORS

District	Councilor	Response
First	I. C. Barclay	Here
Second	H. C. Wadsworth	Here
Third	A. P. Hauss	Here
Fourth	J. C. Elliott	Here
Fifth	A. M. Mitchell	Here
Sixth	W. U. Kennedy	Here
Seventh	Walter Portteus	Here
Eighth	E. H. Clauser	
Ninth	F. T. Romberger	Here
Tenth	W. H. Howard	Here
Eleventh	C. S. Black	Here
Twelfth	A. Jerome Sparks	Here
Thirteenth	Alfred Ellison	Here

PAST PRESIDENTS

Past President	Response	Past President	Response
C. S. Bond		J. H. Weinstein	Here
W. H. Stemm		E. E. Padgett	Here
E. M. Shanklin	Here	R. L. Sensenich	Here
W. R. Davidson	Here	Herman M. Baker	
Charles N. Combs	Here	E. M. VanBuskirk	
George Daniels	Here	Karl Ruddell	Here
C. E. Gillespie		A. M. Mitchell	Here
A. B. Graham		M. A. Austin	Here
F. S. Crockett	Here	Carl H. McCaskey	Here

OFFICERS

Officer	Response	Officer	Response
J. T. Oliphant	Here	T. A. Hendricks	Here
N. K. Forster	Here	Albert Stump	Here
A. F. Weyerbacher	Here	C. A. Nafe	Here

DELEGATES TO A.M.A.

D. F. Cameron, Fort Wayne
H. G. Hamer, Indianapolis

In addition to those who answered the roll call, the following were present:

Robert M. Kelsey, secretary, LaPorte County Medical Society
William M. Dugan, secretary, Indianapolis (Marion County) Medical Society
M. O. Klingler, president, Marshall County Medical Society
L. W. Vore, secretary, Marshall County Medical Society
Wemple Dodds, secretary, Montgomery County Medical Society

THE PRESIDENT: There being a quorum present, I declare the meeting ready for business. I want to make a short explanation of the ground rules. If we let every one talk as much as he desires to talk today, perhaps we might be here for two or three days. The Chair, therefore, will ask that no one speak more than once on any subject without asking the consent of the House. We have no desire to limit the amount of debate and the time that a man speaks, but we will ask, if you desire to speak more than once, that you ask for the consent of the House before you speak the second time. I want each one of you when you speak to stand up and announce your name because we have a new reporter who is entirely unfamiliar with the names of this group of men and their faces, and she would not be able to get your name unless you announce it at the time that you stand up.

We have with us this morning the President of the Medical Association of the neighboring state of Michigan, and I want to introduce him to you—Dr. Brunk. (Applause)

THE PRESIDENT: I desire to call on the Chairman of the Reference Committee on Insurance to read again the report which constitutes the question before this body—Dr. Crockett.

DR. CROCKETT: Mr. President, I move that the report of the Reference Committee which was tabled at the last meeting now be taken from the table for consideration at this time.

THE PRESIDENT: I think that the motion was not tabled, Dr. Crockett, merely the discussion on Dr. Howard's motion was postponed until this time. Is that not right, Dr. Howard?

DR. HOWARD: Yes, that's right.

THE PRESIDENT: Is there a second?

Motion duly seconded.

MR. PRESIDENT: It has been moved and seconded that the question at the last meeting now be placed under discussion again. As many as are in favor thereof say *aye*, contrary *no*.

The ayes have it.

DR. CROCKETT: Mr. Chairman, since we have in Dr. Brunk a man who has broad experience over a number of years, would it not be the wise thing for us to have him give us something of an overall picture of what the situation is as he knows it, before we consider this resolution or this report?

THE PRESIDENT: Do you make that as a motion?

DR. CROCKETT: I would make that as a motion—that we have Dr. Brunk give us a broad overall picture of this problem as he has known it in Michigan, preceding the consideration of the report of the special committee.

Motion seconded.

THE PRESIDENT: There is a motion, which has been seconded, before the House that Dr. Brunk, President of the Michigan State Medical Society,

be asked to speak on this question. Now, are you ready for the question?

Question: As many as favor hearing Dr. Brunk, say *aye*, contrary *no*.

The ayes have it.

DR. BRUNK: Mr. Speaker, Members of the House of Delegates of the Indiana State Medical Association, first of all I bring you greetings from the profession of Michigan; secondly, I came here not to speak or teach, but to listen to a group of men, whom I am sure have very liberal ideas, discuss the economic phases of medicine. I have been listening to discussions of this problem in Michigan since about 1930. I think it was about 1932 when we sent a delegation to England to study the system over there. We developed certain ideas quite early, and about four or five years ago we put them into effect.

As I said before, I came to learn and not to teach. However, I shall say a few words on the general topic and not anything specific about the prepayment plans now operating in our state. If there are any questions you would like to ask then, I shall try to answer them if I can do so, although I am not an expert on medical plans.

We have had a plan operating in Michigan now for a little less than five years. We have had a great many problems, of course, during that time; we have made many mistakes and are still making mistakes, and we do not know the answer to this problem by a long shot. I think, however, that it is fairly well established in the minds of most medical men that there is a definite trend on the part of the public toward some form of health insurance.

This trend is largely toward government insurance. I believe that that is pretty well proved by the various surveys of public opinion that have been made throughout the country. I speak particularly of the *Fortune* survey made about two years ago, at which time it was shown that about 75 per cent of the people desired government medicine—we call it “political medicine” in Michigan. About a year later the Gallup poll showed that 59 per cent wanted some form of federal health insurance. In the National Physicians Committee survey, although I don’t recall the exact percentages, the vote again was fairly large, and quite recently a poll under the auspices of the University of Colorado showed that about 90 per cent favored some form of health insurance. Finally, there is the California survey in which the percentage again is rather high.

In Michigan we have had our own plan operating now for about five years. You would expect that the presence of such a plan would show some effect on the public mind, and this point was confirmed in a recent Michigan survey which demonstrated that only about 39 per cent of the people of Michigan want some form of government medicine, while a larger percentage want some sort of plan

developed by the medical profession and under the control of the medical profession.

The eagerness with which the public is accepting our plan seems a very strong indication that the public is favorable to the medical profession operating or at least controlling some plan. We now have in our plan around 700,000 subscribers. The companion plan—that is the hospital plan—has nearly 1,200,000 subscribers, and that all has been obtained in a period of only a few years.

From our experience, we don’t believe that the public as yet wants a complete coverage plan. I mean by that, a plan that will cover all phases of medical care, home calls, office calls and what not. In the first place it seems expensive, or costs more than the people are willing to pay. We started out with a complete coverage plan and during the first seventeen months we went in the red about \$130,000. It was soon shown that our subscription rates were not nearly high enough to permit us to render that kind of complete service. To begin with, we had gathered all the statistics that we could get to determine how much medical service the average family would want. We found an amount which seemed to be about right and, to be safe, we doubled that and added something for overhead. Still we found that our rates were scarcely half high enough to pay the costs. We were forced to cancel those subscriptions for this reason.

Furthermore, the public was not especially interested in buying protection that cost that much. For example, during the same period that we were writing complete coverage contracts, we had also developed a limited contract to cover surgery, obstetrics and anesthesia. All told, we sold only 7,300 of the complete coverage contracts, while during the same period we were selling 350,000 of the partial coverage contracts. The public was paying only half the rate which we should have charged for the complete coverage, but still was not interested in buying it. Our experience shows pretty clearly that the people are interested in protection against major expenses such as those of surgery, but are not as yet interested in prepayment for minor ailments. We are now working on a contract to be presented to the public that will offer medical care in the hospital as well as the present surgical care.

Now there are two things that I believe are very basic and fundamental in any program. The first is obvious. That is the need for a prepayment plan of some kind, with the public budgeting for major illness and paying on a monthly installment basis. The second—and I know that it involves great differences of opinion—is the provision of complete coverage of major illness for certain income levels. When I use complete coverage in this sense, I do not mean complete provision of medical care in the home, the doctor’s office and the hospital, but complete coverage of certain major illnesses so that at least the low-income subscriber knows in advance that he will have nothing further to pay for these particular illnesses. We have this

sort of guaranteed complete coverage in Michigan. Our contract provides complete surgical care in the hospital for a certain income group. For higher income groups, our plan operates as a cash indemnity plan. Because our program does furnish complete surgical care to the income class most in need of this guarantee, we call it a "Medical Service Plan" and not cash indemnity insurance. It provides medical or surgical service rather than cash payment.

We are operating under a special act which we got from our legislature. I understand that in Indiana you could not operate in this manner because you have no enabling act. Our method is not the only one. In some respects, a cash indemnity plan may work out even better than a service plan, and I say that for this reason: If you do offer complete coverage to a certain income group, those beyond that group in our medical service plan many times have a wrong impression. They think that they also are entitled to complete service with no extra charge, and doctors sometimes have some difficulty convincing subscribers that because they are in a higher income bracket they should pay a difference.

If you start out with a cash indemnity plan, I can see where there might be less misunderstanding. But I do believe that if you have a cash indemnity program, it is going to be necessary to satisfy the public, to have a fee schedule that will offer complete coverage to the lower-income groups. That is the element that I believe to be basic in the public demand at the present time. I think it is going to get worse. Complete coverage, presumably to all income classes, is what the government is going to offer. If we are going to develop something that will keep the medical profession under the control of the profession and not let some outside organization—government, or whatever it might be—tell us how to run it instead of our telling them how to run it, we will have to offer complete coverage for that particular low-income group.

In Michigan we have a fee schedule that is decided by the medical profession itself. The committee called in the nose and throat men, the surgeons, the pediatricians, the obstetricians, and all of the specialists. They sit down together to discuss individual procedures and to try to develop a fee schedule that pays a fee somewhat comparable to, if not entirely the same as, the fees that are customary for each procedure for the income group in question. This method is working out very satisfactorily. We do not have 100 per cent cooperation but about 70 per cent of the profession participates. Indirectly, I think that the participation is higher than that, for in addition to those doctors who have signed the formal agreement, many others are practically living up to its intent and perhaps most of the rest are not charging much above our fee schedule in very many cases. Public pressure has some influence, but chiefly the profession supports the program because the fee schedule is just about

the same as that which individual doctors have been charging.

To begin with, we didn't have our subscription rates high enough to pay the fee schedule and it was necessary to raise them. Before the increased rates could be put through and begin to take effect, however, we suffered a loss. Not having reserves to absorb the loss, we had to delay payment to doctors. For a period of five months we also reduced our fee schedule by 20 per cent. Finally we were able to raise our rates, to pay the doctors immediately, and to re-pay the losses taken by our doctors under the reduced fee schedule. We are now in the black after having been in the red to the extent of over half a million dollars. That doesn't seem such a large deficit if you know how many subscribers we have and how much money has been accumulated. We have about 700,000 subscribers and the amount of money collected in a four-year period was a little better than \$10,000,000. We have paid around \$9,000,000 to physicians. The balance represents our overhead—which is very low, running about 10 per cent—and went, of course, to operating the plan.

Now I believe that if you don't develop a plan, the government will. It will be on a compulsory basis and there will be full coverage. I don't think we have to go very far to convince ourselves that the government would try to operate it just that way, much after the fashion of the law to provide for soldiers' wives and children, the so-called EMIC Bill covering obstetrics. It is true that the government consulted with the medical profession in most states regarding this measure. But while none of the states wanted to cooperate, we are all cooperating more or less. We are doing so in Michigan, although not by advice of the Michigan State Medical Society. It is significant that, after fixing the EMIC schedule, the government established a specific provision in the application which the doctors must sign to certify that the woman is pregnant and needs services. When he signs that certification, the doctor also signs an agreement to accept the EMIC fee and no additional fee from the patient whatever, even as a gift, because gifts are not allowable and carry a penalty. If the government undertakes a health insurance program, it also will be on a similar full coverage basis.

I think that this type of program is coming—coming very fast. I think that our own plans cannot grow too rapidly if we are to prevent it. In Michigan, for example, we are facing a constitutional amendment which would provide for complete medical coverage to all, which would go far beyond the Wagner-Murray-Dingell Bill. It will be placed on the ballot by popular petition. We understand the petition to be ready for circulation with the apparent backing of the labor organizations. If enough signatures are obtained, it will come to a vote in the spring election. They are very smart in proposing to do it that way because there is usually a very light vote in the spring. Organized labor can get out its vote, and I doubt that there is very much

that we can do. But if we don't do something, we are going to have a medical coverage plan in Michigan that will be covered entirely by constitutional amendment. That is partly why we are anxious at this time in Michigan to enroll additional subscribers to our own plan as rapidly as we can and to set up a program that the government cannot duplicate.

Our survey of public opinion shows that the public decisively favors professionally-sponsored medical protection. Specifically, the question was asked as to whom they would like to have set up a plan—the medical profession or the labor unions. To our surprise, as strong as labor is in Michigan, less than 1 per cent of the population wanted labor to set up a plan of its own, so we feel somewhat encouraged.

I think that is all I have to say. Any questions that I can answer, I will be glad to do so.

THE PRESIDENT: Dr. Crockett, you may continue.

DR. CROCKETT: Thank you, Dr. Brunk. I will read the Reference Committee's report as read to you before the last meeting.

"Your reference committee has carefully read and discussed the report of the Permanent Study Committee on Health Insurance, as it appeared in the September issue of *THE JOURNAL*. We wish to commend the committee for the excellence of its report. It is evident that a large amount of time and study was devoted to its preparation. Your reference committee was in session all day yesterday, hearing those interested in this report.

"The opinion expressed was overwhelmingly in favor of some plan being proposed by this session of the House of Delegates. It is recognized that the profession is not of one mind concerning the proposed medical service plan. Thinking along this line has fallen largely into three groups, the first group favoring the formation of a service plan by the physicians themselves, such as that published in the report of the permanent committee. The second group believes that an indemnity type health insurance should be formulated. In both instances the opinion of those appearing before the committee was that whichever type is agreed upon by this House of Delegates, the corporation formed to carry on the business should be organized, owned, and operated by members of this association, with the advice of the Council. There is a third group that believes that the association should enter into no plan whatever. While opinion differs as to the plan we should adopt, the majority favors an indemnity form of insurance.

(This was testimony as we received it before the reference committee.)

"The Permanent Study Committee on Health Insurance, after long study and canvass of similar activities in other states, proposed in their report that we organize our own non-profit corporation to provide medical service to certain wage groups. We recognize that such medical groups have worked very well in other states, but we feel that the majority of those who appeared before our

committee favored an indemnity form of insurance for Indiana. This method of direct payment of benefits to beneficiaries is in line with the accepted principles of physician-patient relationship that has always been the accepted policy of this association.

"Your committee is of the opinion that the financing of the plan adopted should be carried out without the use of funds at present in the treasury of the state association.

"Your committee, therefore, recommends and moves that the state association form and operate its own non-profit indemnity plan of health insurance.

"Second, your committee recommends the appointment by the president, with the advice of the Council, of a committee to carry out the provisions of the foregoing motion."

Now, gentlemen of the House, there seems to be a considerable number of questions about that first motion, since it seems to include three or four definite things which you are called upon to decide, so at the suggestion of our president, Dr. Oliphant, your reference committee has sub-divided that first motion and we now, with your permission, submit it as four motions, the meaning remaining the same, the wording being a little more definite and elaborate.

Our first motion will be:

(1) Your committee recommends and moves that the state medical association approve a prepayment plan of health insurance.

Our second motion:

(2) Your committee recommends and moves that the state medical association approve and sponsor a non-profit mutual indemnity type of health insurance.

Our third motion:

(3) Your committee recommends and moves that this prepayment plan of health insurance should be sponsored by the state medical association and organized and operated by members of the association who have been selected and appointed by the president of this association with the advice of the Council.

Our fourth motion:

(4) Your committee recommends the appointment by the president, with the advice of the Council, of a committee to carry out the provisions of the foregoing motions.

I have given you the overall which your committee wants you to consider, and I will now re-read the first motion for consideration, which I will move on behalf of the reference committee.

(1) Your committee recommends and moves that the state medical association approve a prepayment plan of health insurance.

I move the adoption of this motion.

THE PRESIDENT: I think, to clear the atmosphere before we vote on this motion, I would like to have the will of the House as to whether we break this down or consider the original. As many as favor breaking down this motion as Dr. Crockett has

indicated, say *aye*—opposed *no*. The ayes have it.

Then the motion before the House is, Shall the Indiana State Medical Association endorse some plan of prepayment medical insurance?—and that question is ready for discussion.

DR. CROCKETT: Mr. Chairman, as the proponent of this measure, I have a few things to say. There have been expressed to me many times a fear on the part of members of this association that we are, by this action, opening the door and inviting, eventually, the government to come in and do a thing to which we are pointing the way. I am not so sure that any of us know what is ahead of us. I am not so sure but what we feel that there are certain social trends, certain tides of public opinion moving in this direction of greater socialization in spite of whether we do something positive or remain in abeyance. Personally, in my own mind, I prefer to go out and meet anything that threatens us in the way of government intervention, government regulations, and I would much prefer that the medical profession go out and meet this problem aggressively, explore the situation, struggle with it, perfect ourselves and our knowledge of what is to happen, of what the whole thing envisages, and be ready to defend ourselves to the best of our ability should the time arrive when on the state or federal level government undertakes to interfere or modify our form of practice. I would much prefer to do that gentlemen, and I believe you would rather do it than sit here quietly waiting until something happens—something that has been done to you and our profession by legislation or administrative directive, let us be aggressive about this thing, let us go out and lick the thing ourselves. We will be stronger for it. We are not going to gain anything by waiting. We have waited long enough. The time has come for us to take some action. Mr. Chairman, has the motion been seconded?

THE PRESIDENT: No.

Motion seconded.

THE PRESIDENT: The motion has been made and seconded that the Indiana State Medical Association go on record as endorsing a plan of prepayment insurance. Are you ready for the question?

DR. HOWARD: Does that approve or endorse, or do we simply endorse the principle of a prepayment plan regardless of anything else? It strikes me that in the motion as stated, with that amount of ambiguity in it, one can't tell for sure about voting for or carrying out the prepayment plan by the medical association.

DR. CROCKETT: It is the purpose of the reference committee to put before you the general proposition or principles. Are we in favor of a prepayment plan of health insurance? If we are, *yes*—if not, *no*.

DR. DANIELS: I am not an insurance man, and I don't want to get in the business. So if you want to know how I stand, I am not for it. I am against the motion when you get ready to move.

DR. VANREED: I don't think it makes any differ-

ence what our personal feeling is. I have to vote as my county society instructed me to do. I may not like it at all, but I don't believe that if we are sent here as a delegate from the County Medical Society that we are supposed to vote according to our own personal feelings. While I may be very much opposed to the action of the medical association, yet I am duty-bound to vote as instructed.

DR. WADSWORTH: Daniels is an ex-president; he is talking for himself.

DR. BLACK: Wouldn't it be well if this body would go on record with an *aye* and *nay* vote from the roll call, so that there would be some definite record and no dispute about the results? If that is in order, I will make it a motion.

Motion seconded.

THE PRESIDENT: There is a motion and second before the House that the roll call be by *aye* and *nay* votes, and recorded.

FROM THE FLOOR: Mr. President, I arise to a point of order on that. If you will make that as an amendment. . . .

THE PRESIDENT: He is right, I will make it as an amendment on the original motion. Is there a second to that amendment?

Seconded by Dr. Thomas.

THE PRESIDENT: The motion on the amendment to this motion is that the vote taken shall be by *aye* and *nay* votes on the roll call. Are you ready for the question?

Question: Those in favor of that say *aye*, contrary *no*. The ayes have it.

DR. SENSENICH: The discussion had probably better be held now than later, so here is some information that has not yet been given publicity. In fact, this is the proof of the minutes of the hearing before the Pepper Committee, the more recent one, and reference was made to the idea that some kind of governmental action would most certainly come very soon; in fact, someone made the statement last night, within six months. I don't know the source of that, and I don't know that anybody knows or can say that anything is going to be done. This is something in the way of information as to the trend of some of the thinkers. In the first place, it is well known and we are in possession of some of the plans that are in preparation. Plans have been in preparation within certain circles within the government over a period of some years, some method of socializing medicine—one method or another. This particular development is a development of the Senate Committee on Education, of which Senator Pepper is the chairman. Education and War-time Medical Service, I think it is called, something of of the kind, but anyway it was a bit illuminating. We had been developing, or I had been trying to develop, in a couple of hours, the things that were important in the giving of medical care—the things that would be endangered or destroyed by any of the proposals that those in the government were thinking, that we knew about. Whereupon Senator Pepper propounded to me one of those long questions—I will not take time to read all of it, but all

of these things I contended were important to medicine—the individual relationship—the freedom of the physician to practice as his scientific teaching directed him—in other words, my idea is to keep the government out of the picture entirely. Then there came the matter of the financial side. We have never opposed the setting up of funds in the prepayment of care, but from what he said, suppose also that we try to preserve as far as possible the right of a patient to make a freedom of choice of his own physician, surgeon, or dentist. I said I thought we would have to in order to bring in the masses of people, and we would have to make the amount of their payments low. I expect we would have to make them uniform. Let us assume that payments would be low in amount and would be uniform to all people. Then suppose the detail of plan which might be conceived of, we will say by the states and in the manner in which unemployment compensations are divided by the states, and the Federal Government should approve the plan that the states might provide or offer, then suppose the Federal Government and the states might, by their own appropriations, make up the difference between the cost of rendering the service and the income from membership which might exist in a given situation. Under some such approach you might, it seems to me, preserve all of these things which you have explained are important, and we would not make it compulsory but voluntary, and still leave the patient the right, for instance, to call up the Central Hospital and say, “I would like Dr. Jones to come to visit me in my home; I am unable to come to the hospital.” If Dr. Jones were not able to come, the patient would call for another doctor. There are two things in that that are significant, and you must recognize this as a basis of and, in part, something that has recently been decided with the Pacific coast Garfield-Kaiser crowd. There comes to mind the idea that the Federal Government, or federal and state governments, would contribute to make up the difference in the insurance plan that would provide the medical service and, of course, with the idea that it would be given as it is now. It was simply paid out of that fund and then the hospital would be the unit which would employ the doctor, and we had a long discussion about that. But in the background, in principle, medicine, I think, has never opposed the budgeting, or at least not in recent years opposed the budgeting in advance of monies to be paid according to the insurance principal to be available for the payment of medical or hospital service, just as it is to replace buildings that have been burned. Furthermore, we have no opposition to the government paying the individual unemployment compensation during the period of unemployment by reason of illness, provided essentially all the way through the government kept its finger out of the actual giving of medical care or anything that tended to interfere with that operation, so that we have not opposed prepayment plans.

It seems of the greatest importance, however,

that we come back again to the same old status. There are certain principles to be preserved, and that is that the physician shall be retained in the position of an independent contractor. Now with reference to whether we should approve or further more of these additional movements which are in activation of the idea of the prepayment plan and operating means which we set up, or some organization to do this work, it seems important that we have in mind this essential thing. First of all, do we want to create a pattern? Secondly, if we do want to create a pattern, we should give thought to the whole matter of having that pattern something which is not destructive to medicine. I digress for a moment—the only reason I know of why service plans were brought into being was because most of the insurance schemes that were set up were not able to comply, financially or otherwise, with the requirements of the various states, and as a consequence they had to guarantee that service be given theoretically, but, in essence, the insurance agencies of the various states would not permit them to set up any machinery in which it was not guaranteed by someone or other that the individual would receive service for which he purchased insurance. There were no reserves, and the doctor had to guarantee to give this service. There are many other things which need not be discussed, but, after all, do we accept the prepayment plan as being a proper method of budgeting in advance for the payment of fees? Secondly, as to the indemnity feature, I think it is absolutely essential, and I am glad to hear Dr. Brunk say that no matter what kind of machinery is set up, the whole purpose of such insurance should be first, last, and at all times to provide funds, not to socialize the funds, but to provide them if the individual has not sufficient money. It is perfectly right that he should budget in advance, but no matter who steps into the picture the physician should be the individual contractor, and if we retain that position not much harm can come to us. If we abandon that, then the government is in a position to step in and say, we will take over your idea—this must be acceptable because you developed it, and then you are in a position which is very weak by reason of the fact that you must say to the government, “We will do it for ourselves but we won’t do it for you,” and 120,000 doctors are not going to be in a position to prevent that at this time. As to the indemnity insurance, I think that some have been badly frightened by the presumed volume of this. Following the meeting of the House of Delegates the other time, I made telegraphic inquiry to all the plans now operating under state sponsorship. There are 1,090,000 subscribers to the various plans, of which Michigan, as Dr. Brunk told you, has 700,000. There are something less than 300,000 included in the medical-sponsored plan on the joint service. Michigan, as Dr. Brunk has pointed out, has up to this time, or has at this time, surgery, etc., but the full coverage which we are considering is a trifle less than 300,000. Someone will say, “What is going to prevent

the government from stepping in?" These figures will have to be given to the Pepper Committee. We can't say that it is going to prevent the government from coming in. However, it will do one thing, if you choose to do it, and that is that it will prepare a pattern of your making, a pattern in which you will retain the individual character of the physician and its contractual relation. I think a mistake was made in Michigan in the participating and non-participating members, for the reason that I do not think it necessary, if you are going to provide the funds, that everyone should be in essentially the same position.

I realize that there is a reason for controlling it so far as the low income group is concerned, but I think some other kind of mechanism should be set up to do that, or we will say, create the willingness of the physician to take care of the low-income group on the basis of the insurance, but by all means not create the same kind of position which has arisen in the EMIC program because this was for the wives and children of servicemen, but the scope is not so tremendous. There seems to be some usefulness in setting up a pattern of the proper kind so that if the government does step into the picture there will be some reason to believe that you will be in a position to insist upon an adoption of a plan that will not be objectionable to you; and lastly, I wished to give you that thinking on the part of the Pepper Committee which has not been given publicity.

DR. ROMBERGER: I speak for myself, because I want to go on record before this House of Delegates. I speak as Chairman of the Council, because your action today will either strengthen or weaken the hands of the Council in carrying out any mandate which this House of Delegates should give to that Council. You are going to be asked to vote *aye* and *nay* upon not only evolutionary but also upon revolutionary principles for the Indiana State Medical Association. Before you vote *aye* or before you vote *nay*, I want to give you some information corroborative of many things which I have thought and discussed before this House for many years, and which have come to my attention within the last twenty-four hours, one thirteen hours ago, and the other one hour ago. Before you vote *aye* or *nay*, ask yourselves in your own hearts, and give yourselves in your own hearts the answer to these two questions.

The one was brought up by our distinguished guest, Dr. Brunk, who gave us a very good exemplification of what has happened in Michigan. When he was through and had laid before us the fact that now after four, five or six years of education of the public in prepayment medical care in which the state association created a pattern and pointed out the way, now, in the spring, this problem is going to be voted upon on a state-wide level by the electorate of the State of Michigan for state government control of medical practice, and Dr. Brunk has serious doubts whether it can be defeated. The second thing which came to my attention thirteen

hours ago was a report on the situation in Ohio and Missouri, and it gave us some information. This report was written by Dr. Young, of Ohio, and among certain informative things, I wish to read verbatim one sentence:

"The Blue Cross in Missouri is at the present time approaching the legislature with a plan to come under the enabling act similar to the enabling act of Ohio, but different in that it would permit the Blue Cross plan to form a corporation for the practice of medicine, employing physicians on a contract basis."

If that is what the Blue Cross is going to lead us into, then we are worshipping false gods. As I understand it, the Blue Cross was formed in 1932. It was sponsored by the American Hospital Association, and you know the answer as well as I. Shall we point the way and set up the plans for the domination of the profession of Indiana by the American Hospital Association, or any other association, or by the state government, or by the national government, or shall we remain free men in the practice of medicine, regulating our own lives and our own ways in the practice of medicine? Shall we allow such domination? I recommend to you the report of Dean Gatch in the last association JOURNAL.

But whichever way you vote, think seriously and vote *aye* or *nay* in accordance with the dictates of your heart and in the light of the information which I have just given.

DR. SPARKS: There are men in this room who attended the meeting at Cincinnati under the auspices of the Council on Medical Service and Public Relations. I was there along with the others. It was the consensus of most of the men there that most of our present difficulty is due to the fact that we were doing exactly as recommended by Dr. Romberger here now—sitting back and doing nothing. Too many believe in doing nothing now because, they say, it is going to be done for us. It may be that some of the things we anticipate are going to happen, and we may not be able to prevent them. But we can at least be doing something about it. And it is the object of this meeting to set up the machinery for such action.

Dr. Portteus and I know, from our conversation with the Michigan men, of the proposed amendment to their constitution, but what the Michigan Medical Society is doing may be just the thing that will defeat the amendment. We went up there and saw the plan in operation; we met the doctors of the supervisory committee. One of the points which Dr. Brunk emphasized, and which I think we have been putting in the background, is that a certain income group must be guaranteed certain services for a specified amount. Whether it is on an indemnity basis or service basis is of no importance. The doctor must agree to do the work, at the beginning of any type of plan, for a specified sum determined by our own association. Unless that is done, the whole purpose of the idea is defeated.

American Medicine has gone far in a scientific

way, but with it the costs of being sick are greater. By spreading the cost over larger groups, experience has proved that all except the indigent can budget for catastrophic illness sums which they can afford. Furthermore, if the plan is under our own control, any surpluses will go for increased benefits as well as bringing fees up to the proper level.

Now, so far as the Blue Cross is concerned, I have no fears as quoted by Dr. Romberger from Dr. Young's letter. I know that he has made an extensive study of this problem and knows a lot more about it than I do. But here again we have experience to point the way. In Michigan, and perhaps other states, they work in the same offices, and take over the job of selling. It is only when the doctors refuse to cooperate that the Blue Cross takes the initiative in organizing medical plans.

DR. NIE: I am instructed to vote against the formation of an indemnity insurance company by the state association. My hands will be tied. I think we are losing sight of the main thing. We are supposed to be interested in the better practice of medicine. A doctor is not supposed to be primarily concerned about the fees he gets. One would think that this is an emergency, that we are scared—afraid something is going to happen in Washington to make us do a certain thing. After all, there are only a certain number of physicians in America, about 110,000 of us on the job now, and we are the fellows that are going to have to do the medical practice. Now, when labor organizations go on a strike, and the employer can't do anything toward settlement, the government takes over the factory and the strikers negotiate with the government, and everything is all right; but supposing the 110,000 or 120,000 physicians of America object, who is the government going to take over then? We are going to have to go ahead and practice medicine, so I don't think we should get excited about any sort of bill. If the Senate Bill No. 1161 goes through; let's take the attitude that that's what the people want, like the Volstead Act—if it's all right, it will stay, and if it isn't, it will go. That's the way with socialized medicine. So much talk about how you are going to get the money. We needn't worry about the practice of medicine. Let's go ahead and John Jones will demand the services and will see that they are paid. We need not worry about finances. We are going to make money, and they have got to have us. I don't think at this time we should do anything—not get scared. We are debating this now because we are afraid somebody is going to do something to us. They can't take your ability away from you, so let's go ahead and practice medicine and not be scared into something because somebody is going to do something to you. (Applause)

Question.

DR. HOWARD: There is only one thing I want to say at all, and it is that at the meeting of our committee most of the controversy has been over whether or not you are in favor thereof, and the committee thought perhaps the thing could be

worked out, say if the committee went in favor of an indemnity plan with perhaps two names on the check and that the men voluntarily agree, if the thing goes through, to accept their indemnifying payment as the whole payment for the low-income group, but I think that the committee is of the opinion that we are in favor of an indemnifying group instead of an insurance plan. That is the only thing I can say about the whole thing. There is a great number of these men that are in favor of our doing something. I personally think that you have to do something about this thing. I think that to sit back and wait for them to take you over is very, very foolish, and it just won't work. I think we should get the air clear before we go any further.

DR. ATKINS: We are neither for nor against the insurance plan. We think that we should exercise more caution. We should have further study. We believe that only a small percentage are familiar with the issues involved. We are not entirely convinced that if we go into this thing we will stop socialized medicine. We are still of the opinion that it might smell a little like the Farm Bureau when it went into the selling game. Furthermore, we recognize that the doctors in practice here are over fifty years of age, and we feel like this plan, if formulated, should be presented to the servicemen before the final verdict.

DR. A. T. JONES (of Madison County): I am here instructed to vote against a medical plan, not because we are against the people having insurance, and not necessarily because we are against the state medical association running an insurance plan, but we don't know enough about it in our county. As I understand it, Michigan, which has more insurance policies than all the others listed, has a matter of about 400,000—that amount of insurance policies does not cover 1 per cent of Michigan state, and if that is all that this insurance reaches, it isn't going very far, and the physicians there are afraid that the people in Michigan are going to outvote the plan. Pretty soon they expect to be changed in spite of their insurance company to payment by the state. For such reasons, I think, our society has instructed its delegates not to vote at this time for the proposed plans.

DR. BRUBAKER (delegate from Wabash County, secretary of "the best district association in the state"): I am instructed to vote against this motion for the present. This good man, Dr. Atkins, right back of me, stated my thoughts exactly. What business have we old "guys" voting when a lot of our young men are fighting to give their blood and life to save the country? I think we ought to vote *no* by all means.

THE PRESIDENT: The secretary will call the roll. Only the names of those will be called who have registered with the committee.

DR. DANIELS: State the motion so I will know how to vote.

THE PRESIDENT: George, the question before the House is: Shall the Indiana State Medical Asso-

ciation endorse some plan of prepayment sickness insurance?

County Delegate—Response

Allen	Wright—My vote is <i>yes</i> through instructions from my county society. If I were voting my convictions, it would be <i>no</i> . Just because it is a doctor's duty to render medical and surgical service to those in distress, I have never been able to bring myself to believe that it is also his duty to furnish a means by which people can secure that service.
	Lohman—Yes
	Catlett—Yes
Bartholomew	Dudding—Yes
Benton	Turley—No
Boone	Schaaf—No
Carroll	Adams—Yes
Cass	Egan—Yes
Clark	Buckley—Yes
Clay	Maurer—Yes
Clinton	Beardsley—
Daviess—	
Martin	Fox—Yes
Dearborn—	Fletcher—No
Ohio	Fessler—No
Delaware—	Stocking—Yes
Blackford	Ball—Yes
Dubois	Blessinger—Yes
Elkhart	Yoder—Yes
Fayette—	Glaser—No
Franklin	Smith—No
Floyd	Polhemus—Yes
Fulton	Stinson—No
Gibson	Clark—Yes
Grant	Lavengood—No
Hamilton	Donahue—No
Hancock	Ferrell—Yes
Harrison	Amy—Yes
Hendricks	Scamahorn—No
Howard	Clarke—Yes
Huntington	Nie—No
Jay	Cring—Yes
Knox	Boyd—Yes
Lake	Verplank—Yes
	Row—Yes
	Pettibone—Yes
	Jones—Yes
LaPorte	Kelly—Yes
Lawrence	Dollens—No
Madison	Elsten—No
	Jones—No
Marion	Garceau—Yes
	Moore—No
	Myers—Yes
	Bakemeier—No
	Ochsner—No
	Dalton—Yes
	Moser—No
	Rupel—No
	Morton—Yes
	Ritchey—No
	Manion—Yes
	Hahn—Yes
	Gatch—No
	Mitchell—Yes
Marshall	Thompson—Yes
Monroe	Dalton—Yes
Montgomery	Collett—No
Parke—	
Vermillion	Casebeer—Yes
Porter	Frank—Yes
Posey	Ranes—Yes
Putnam	Wiseman—No
Randolph	Dininger—No
Ripley	Smith—Yes
Rush	Atkins—No
St. Joseph	Giordano—Yes

County Delegate—Response

	Balla—Yes
	Carter—Yes
Shelby	Inlow—Yes
Sullivan	Crowder—Yes
Tippecanoe	Van Reed—Yes—As instructed by the society, I vote <i>yes</i> —personally, I am opposed.
	Thomas—Yes
Vanderburgh	Miller—Yes
	Acre—Yes
Vigo	Nay—Yes
	Topping—Yes
Wabash	Brubaker—No
Wayne—Union	Ross—No—I yield to Dr. Thompson.
	Thompson—No
Wells	Wybourn—Yes
<i>District Councilor—Response</i>	
1st District	(Dr. Barclay—I'd like to say that only two delegates from Vanderburgh County were called).
Vanderburgh County	Welborn—Yes—Our meeting voted about 20 to 3 against the state controlling such insurance. There were no particular instructions of the delegates. They were in favor of some plan, so I'll vote <i>yes</i> .
1st District	Barclay—Yes
2nd District	Wadsworth—Yes—Four of my counties voted <i>yes</i> , so I'll vote <i>yes</i> .
3rd District	Hauss—

DR. HAUSS: Mr. Chairman, I would like to say a few words as Councilor of the Third District, and also as a member of the Permanent Study Committee on Health Insurance.

We have taken a poll of the Third District. We have had several county or joint meetings, and the reports I have received from these meetings indicate that all except one county were in favor of some sort of a prepayment plan.

I want to say, as a member of your Permanent Study Committee on Health Insurance, that we worked on this subject for a year. We worked hard to carry out the mandate of last year's House of Delegates, to prepare for you "the most feasible plan of prepaid medical service." We were given those instructions, and we brought in this plan.

I think that the people—the general public—want to know whether the medical profession is in favor of solving their problem, and for that reason I believe that this assembly should vote in favor of some plan for prepaid medical service.

Now then, I am going to say something that may surprise the other members of the Health Insurance Committee. In all sincerity, I believe, from the discussion we have had here today and from the discussion we had at Cincinnati two Sundays ago, that we are not ready to definitely adopt a final plan until we have given it further study, and until we have heard something from our colleagues overseas, who are in the armed forces.

After the present motion is voted upon, and I hope it will be *yes*, I am going to make a motion that may prolong the consideration of this plan for another year.

DR. HAUSS: I am not making the motion now.

Councilor—Response

3rd District	Hauss—Yes
4th District	Elliott—No

	Councilor—Response
5th District	Mitchell—Yes
6th District	Kennedy—Yes
7th District	Portteus—Yes
8th District	Clauser—
9th District	Romberger—No
10th District	Howard—Yes
11th District	Black—No
12th District	Sparks—Yes
13th District	Ellison—Yes

Past Presidents	
Davidson—Yes	Sensenich—Yes
Shanklin—Yes	Baker—
Combs—Yes	Van Buskirk—
Daniels—No	Ruddell—
Crockett—Yes	Mitchell—
Weinstein—Yes	Austin—No
Padgett—Yes	McCaskey—

THE PRESIDENT: Is there anyone else present entitled to a vote whose name has not been called?

FROM THE FLOOR: Did Mitchell vote as ex-president?

THE PRESIDENT: He voted as a Councilor.

FROM THE FLOOR: Let him vote as ex-president. George only voted once, in a loud voice.

THE PRESIDENT: No question about George voting. The result of this vote is: 66 delegates voted *yes*, 33 delegates voted *no*, therefore the motion is carried.

At this time Mrs. G. D. French, chairman of the Red Cross Nurses Recruiting Committee, was introduced and made a plea for nurses for the armed forces.

DR. CROCKETT: In order to put before this House of Delegates the type of medical plan that you may want, your committee recommends and moves that the State Medical Association approve and sponsor a non-profit mutual indemnity type of prepayment health insurance.

Mr. Chairman, may I move the adoption of that motion?

THE PRESIDENT: Is there a second to that motion?

DR. PORTEUS: Second the motion.

THE PRESIDENT: Your Committee recommends and moves that the State Medical Association approve and sponsor a non-profit mutual indemnity type of prepayment health insurance. That is the question before the House. Are you ready to vote on that question?

The secretary will call the roll.

The secretary suggests that perhaps the roll call on that motion would not be necessary; do you desire a roll call?

DR. W. A. THOMPSON (of Wayne-Union): I move that it be adopted by acclamation.

THE PRESIDENT: As many as favor this motion will make it known by saying *aye*, contrary *no*.

After the voting, the President, continuing: We will have a roll call.

County	Delegate—Response
Allen	Wright—Yes
	Lohman—Yes
	Catlett—Yes

County	Delegate—Response
Bartholomew	Dudding—No
Benton	Turley—No
Boone	Schaaf—No
Carroll	Adams—Yes
Cass	Egan—Yes
Clarke	Buckley—Yes
Clay	Maurer—Yes
Daviess-	
Martin	Fox—Yes
Dearborn-	
Ohio	Fletcher—No
	Fessler—No
Delaware-	
Blackford	Stocking—Yes
	Ball—Yes
Dubois	Blessinger—No
Elkhart	Yoder—Yes
Fayette-	Glaser—Yes
Franklin	Smith—Yes
Floyd	Polhemus—No
Fulton	Stinson—No
Gibson	Clark—No
Grant	Lavengood—No
Hamilton	Donahue—No
Hancock	Ferrell—No
Harrison	Amy—No
Hendricks	Scamahorn—No
Howard	Clarke—Yes
Huntington	Nie—No
Jay	Cring—No
Knox	Boyd—Yes
Lake	Verplank—Yes
	Row—Yes
	Pettibone—Yes
	Jones—Yes
LaPorte	Kelly—Yes
Lawrence	Dollens—No
Madison	Elsten—No
	Jones—No
Marion	Garceau—No
	Moore—Yes
	Myers—Yes
	Dalton—No
	Bakemeier—Yes
	Ochsner—No
	Rupel—May I ask a question—Is it implied in this motion that the society form a non-profit indemnity organization owned by the society?

DR. CROCKETT: Let me read the question:

We recommend and move that the State Medical Association approve and sponsor a non-profit mutual indemnity type of prepayment health insurance.

DR. RUPEL: What do you mean by sponsor?

DR. CROCKETT: That is taken in in the next resolution which will be that we will recommend a prepayment plan of health insurance which should be sponsored by the State Medical Association and organized and operated by the members of this Association who have been selected and appointed by the President of this Association with the advice of the Council.

County	Delegate—Response
	Rupel—No
	Moser—No
	Morton—Yes
	Ritchey—No
	Manion—No
	Hahn—No
	Gatch—No
	Dalton—No
	Mitchell—Yes

County Delegate—Response

Marshall	Thompson—Yes
Monroe	Dalton—No
Montgomery	Collett—No
Parke-	
Vermillion	Casebeer—Yes
Porter	Frank—Yes
Posey	Ranes—Yes
Putnam	Wiseman—No
Randolph	Dininger—No
Ripley	Smith—Yes
Rush	Atkins—No
St. Joseph	Giordano—Yes
	Balla—Yes
	Carter—Yes
Shelby	Inlow—Yes
Sullivan	Crowder—No
Tippecanoe	Van Reed—No
	Thomas—Yes
Vanderburgh	Miller—Yes
	Welborn—Yes
	Acre—Yes
Vigo	Nay—No
	Topping—No—The Vigo County delegation have been instructed by their society to vote for an indemnity plan but against a mutual insurance plan. According to the wording of the motion, it is impossible for us to make an intelligent vote because both of those propositions are inserted in the same motion. Therefore we must vote <i>no</i> .
Wayne-Union	Ross—Yes
	Thompson—Yes
Wells	Wybourn—Yes
White	Gable—

Councilors

1st District	Barclay—Yes
2nd District	Wadsworth—I'd like to ask Monroe County how they voted? Monroe County voted <i>no</i> , Daviess-Martin <i>yes</i> , Sullivan <i>no</i> , and Knox <i>yes</i> , so I will vote <i>yes</i> $\frac{1}{2}$, <i>no</i> $\frac{1}{2}$.
	Wadsworth—Yes $\frac{1}{2}$, No $\frac{1}{2}$
3rd District	Hauss—Yes
4th District	Elliott—No
5th District	Mitchell—No
6th District	Kennedy—Yes
7th District	Portteus—Yes
9th District	Romberger—No
10th District	Howard—Yes
11th District	Black—No
12th District	Sparks—Yes
13th District	Ellison—Yes

Past Presidents

Davidson—Yes	Weinstein—No
Shanklin—Yes	Padgett—(Left meeting)
Combs—No	Sensenich—Yes
Daniels—No	Van Buskirk—(Not here)
Crockett—Yes	Austin—

THE PRESIDENT: Due to the split personality of Dr. Wadsworth, we have 52½ votes for the motion and 45½ votes against the motion, therefore the motion is carried.

DR. CROCKETT: Mr. Chairman, the third motion before the House from your committee is as follows:

Your committee recommends and moves that the prepayment plan of health insurance should be sponsored by this state association and organized and operated by members of the association who

have been selected and appointed by the president of this association with the advice of the Council.

I move the adoption of this motion.

The motion was seconded by Dr. Thomas, of Lafayette, and Dr. Portteus, of Franklin.

THE PRESIDENT: Your committee recommends and moves that the prepayment plan of health insurance should be sponsored by the State Medical Association and organized and operated by the members of this association who have been selected by the president of the association with the advice of the Council. That is the question.

DR. ELSTEN: It is apparent that there is a great deal of sentiment in this organization for some kind of insurance program, but I think there is a wonderment in the minds of a great many of us as to whether or not the society itself should go into the insurance business, and I wonder if we might not call upon Dr. Howard or some member of his committee to inform us as to what study they have made as to whether a private insurance company could do this job for us.

DR. HOWARD: We have been over this thing, backward and forward, for the past year and three months. As to whether or not a private insurance company can do this job for us, the answer is that the private insurance companies are trying to do so now, but they aren't doing very much. There are not a great many of these cash indemnity policies in force, and the insurance companies haven't our interest at heart at all. They write this insurance primarily as a money-making proposition, and they are using you men and me, and the rest of the profession, to make money for themselves.

What we propose is a prepayment plan of medical service or indemnity. We are trying to get people to provide for the cost of their medical service by paying their money in advance. As a matter of fact, the Supreme Court has ruled that the proposed plan is not insurance at all. I believe that Dr. Sensenich and Mr. Stump will tell us that this is the case.

If you are to have a prepayment plan, you want to be the one who is running the business. You don't want anyone else running it for you.

In the first place, it is a matter of money. They have found that they can run their plan in Michigan on an overhead of only 11 per cent, and I am sure we can do equally as well because I think we're fully as smart in Indiana. There isn't an insurance company in the country that can do better. The best offer we have had from a private insurance company was that they would pay us 75 cents on the dollar, with the insurance company taking the remaining 25 cents for overhead and profit. If this thing actually clicks, and you get as large a number of subscribers as they have in Michigan, a 5 per cent difference would amount to \$165,000 a year, whereas the actual difference between your cost of doing the business yourself and your cost of having a private insur-

ance company do it is not 5 per cent, but more than 10 per cent. Thus, if we operate the program ourselves, we will retain some two or three hundred thousand dollars that would go to the insurance company and not to the medical profession.

I don't see any sense in turning this thing over to a private insurance company. We don't expect to run it ourselves; we expect to hire someone who has insurance experience and can run it for us. I don't know anything about running an insurance company, but I do know that you can hire the right kind of men if you pay them enough money. The insurance companies hire them, and you can hire them.

If we operate the plan ourselves, we can set up our own schedule of fees. We can not, of course, set up a schedule of fees bigger than the premium will cover, but it can be set at the top, and not down where the insurance company can make two or three hundred thousand dollars off your services.

The two greatest items in the cost of a private insurance company in this business are the sales cost and the adjustment cost, and the latter is one of their largest expenses. They must have a large force of men to adjust their claims so they won't have to pay out money on false or exaggerated claims. However, if we set up and operate the plan ourselves, with our own company, our own county societies can check the claims our members turn in. And you know that when your own colleagues check your figures and your claims, you'll keep them right. Each of us wants only what is coming to us, but we don't want one fellow down the line to be getting twice as much for the same service as we are. We want an equitable distribution of the money, and, if your own colleagues check on the claims that are paid, I think we'll get it. Every doctor knows who is the right fellow, and who is the one that pads his bills. And by meeting once a month to check these claims we can handle our own adjustments. The insurance company cost would be 5, 10, or even 15 per cent for handling adjustments that we can handle for practically nothing. And that is another reason I think we should do this thing on our own rather than have some outside company step in and do it for us.

It would be worth a good many thousands of dollars to an outside company to sell this group on a companion policy to Blue Cross, but remember that this private insurance company will set the fee schedule and will get any excess profits under the plan.

If, however, the plan as we have set it up goes through, and there is more money paid in than is required to meet your claims, there are only three things that can be done with this excess: You can lower the premium; you can increase the payments to the doctor; or you can increase the service. If the plan is operated by an insurance company, and there is any excess money made, they will stick it in their pockets. You can't expect

them to raise the fee schedule, for they have taken the risk of establishing and operating the plan.

DR. A. M. MITCHELL (of Vigo): Dr. Howard stated that Washington says this is not insurance. But if we organize in this state, we have to organize under the insurance laws of the State of Indiana, and that makes us an insurance company, and it doesn't make any difference what Washington says. It is what the State of Indiana says.

Probably a lot of you don't know, but I know that the first thing that costs in setting up your own insurance company is \$25,000 deposited with the Insurance Commissioner of the State of Indiana. The second thing is to organize. This is going to cost you twenty or twenty-five thousand dollars, and still you are not in business. Under this type of insurance, and this form of company (mutual), it will be necessary to sell \$25,000 worth of policies or get that much premium before you can do any business, because your insurance does not become operative until you have sold that much.

Now there is no company that you are going to sell in groups. If they already have a plan, they are not going to drop the plan they have and wait until you sell \$25,000 worth of insurance before you become operative. That might take us ninety days; it might take six months. If they had a plan and they wanted to take out our plan, it would be necessary for them to drop the plan they had, because they could not have double coverage. And if they did, their employees would be without any coverage until you were in operation. Where is the \$50,000 going to come from to start this thing? Can Howard answer that?

DR. HOWARD: At the present time, or for the past six months, the Indiana Bell Telephone Company has been waiting until we either turned this thing down or went ahead, to come in with us on a companion policy to the Blue Cross. The Indiana Bell has repeatedly been in the office offering to advance the \$25,000 advance premiums as one unit to start this thing off. Isn't that right, Mr. Hendricks?

MR. HENDRICKS: I don't know anything about that. There was nothing about advancing that money. The Indiana Bell is waiting, holding up their contract with the Blue Cross, until this group acts.

DR. HOWARD: I am mistaken about that. I was misinformed. In fact, I quoted it in front of Tom, to make sure that I was right. The Illinois Bell. . .

MR. HENDRICKS: I don't know anything about the Illinois Bell.

DR. HOWARD: As to getting companies to subscribe for the first group of policies, I don't think that will be difficult. As to the \$25,000 that you will have to advance, we have enough other things to discuss without trying to figure out where you are going to get \$25,000. I am certain that there will be no difficulty in raising this sum, if you are interested in establishing and operating your own plan.

DR. DAVIDSON: I would like to ask if the words "with the advice of the Council" mean that the Council shall only approve the appointment of the members of this committee, or that the Council shall continue to act as an advisory board, to be consulted in managing the organization as it will be set up?

DR. CROCKETT: Dr. Davidson, the organization to conduct this business should not be the state association, but should be composed of members of this association who were appointed by the officers of the State Medical Association. That would keep it in line and under the control of our State Medical Association. The business of the insurance company would not be the business of the State Medical Association but of the particular group that was named after this committee, this original committee, had done the organizing and started the thing going.

DR. DAVIDSON: I understand then that the Council will act only in approving of appointments of the members of the committee.

DR. A. M. MITCHELL: Another question comes up in my mind. After the \$50,000 is put up to get the thing going without selling any insurance, both as to organization and the deposit with the state, whoever puts it up, whether it be a group of doctors or anybody else, how do they get their money back?

MR. STUMP: Mr. Chairman, that money could be advanced on certificates of advancement which, under the statute, could bear interest at a rate not to exceed 6 per cent. A non-profit organization can accumulate reserves, and it can pay these certificates of advancement. It can also accumulate surplus, but it can't distribute the surplus to any person except to policy holders or in reduction of indebtedness. It is non-profit because nobody can make a profit on his investment in it. But it can accumulate reserves and surplus, and the payments of certificates of advancement and interest thereon can be made out of the earned surplus. I might say that the Blue Cross Hospital organization borrowed its \$25,000 on 4 per cent interest, and that will be paid at the time when there is a surplus that has been earned out of which payments can be made. Now that money was borrowed at 4 per cent interest—it was not money, it was not cash; it was government bonds, and from that 4 per cent interest obligation they deduct the amount of income from the bonds which makes the actual interest payment from the Blue Cross organization 1½ per cent on its original \$25,000. Now there was a suggestion made also that it would take \$25,000 more to put a mutual insurance plan in operation. It probably would not require that amount. To get the Blue Cross in operation, it took about \$12,000, and that was also borrowed on certificates of advancement which carried a 4 per cent interest charge.

DR. A. M. MITCHELL: Concerning the Bonds for the Blue Cross, I know who put them up—he is a philanthropist, and because he is primarily a director of a hospital, he would have given it to you

if he thought it was the smart thing to do, so I don't think the Blue Cross getting that for 1½ per cent is anything but pure philanthropy.

DR. DANIELS: I don't know, but I am not looking for business to be so hot after this war is over. Now supposing the money is put up, the \$25,000, just how strong a string is there to it that it would ever come back to this association? You have made contracts with the people, and the state would expect you to carry out your contract. Now what happens to the \$25,000? I am just in the primer in this business. I want to know.

DR. NIE: From the way the discussion is going now, one thing is evident. You are gradually getting your eyes open. Organizing an insurance company by an association is really a job. Even after you get the \$25,000 on deposit with the Indiana Insurance Department, you have to have a building, you have to have agents, you will have a lot of expense. Now it is evident here that a lot of us doctors don't know very much about the insurance business. I would say that most of you should see that there are a lot of things to look into before you make any definite decision. It is not as easy as it looks.

DR. ATKINS: Another question in my mind—are we jeopardizing the prestige of this association? If we fail, the finger of scorn will be pointed at us; if we succeed, we will be called a "trust." I cannot accept the Michigan plan as a perfect success.

DR. CROCKETT: Perhaps I could add a little something that might answer this question that has caused some commotion. The plan is to be sold by the Blue Cross organization with their Blue Cross policy as a complete plan so that there is not a separate organization that we must set up. The costs have been reduced so that the complete sale cost is not greater than if either one sold individually. I think in Michigan the sales cost through that sort of plan has been 4 per cent.

THE PRESIDENT: There is a request from the floor that Dr. Nafe be asked to talk on this subject as chairman of the Executive Committee. Dr. Nafe is not a delegate, and it would require the consent of the House. Are you favorable to that?

(House): Yes.

We will call on Dr. Nafe.

DR. NAFE: It seems to me that we have gotten this far in this question—we have debated it up and down, and now I would think that we are more or less bound to the view that we are going to do something. It would seem to me that the only question before the House is the question: shall we sponsor an insurance company, letting a commercial company do it for us, or shall we run our own company? Concerning the first two points, personally I have been highly in agreement with the action of the House. The Executive Committee is bound by the decision of the House of Delegates, but personally I felt that the actions were correct. But as to the third, I am still of an open mind as to

what we should do. Do you want us as an association to endorse or sponsor a commercial company, or do you want to run your own company? When I first thought of this a year or two ago, when this question was first proposed, I was entirely in favor of our sponsoring a company and not doing this ourselves. I am still not quite convinced that we ought to do it. At the same time I will admit that I wonder if the reason that I decided that in my own mind is because I, and the rest of us, don't want to assume the responsibility which possibly we should, and which is probably ours to assume. I don't know what we ought to do at this point, whether we should select a company and sponsor it, or whether we have our own company; as far as I am concerned I have no complete feeling about it. I do wonder, however, concerning the motion they made of having a mutual company, whether the Ohio plan of having a stock company would not have been better. You know Dr. Young over there, a very able young man, felt that we should have a stock company, so that we could completely control it, but if it was a mutual company there might be the possibility of the stockholders taking it out of our hands. Now, as I say, there is one question before us: do we want to sponsor a commercial company, or do we want to do it ourselves? Then the next question would be: if we do it ourselves, is it better that we have a stock company or a mutual company? I have no positive conclusion at all as to what is the right thing to do about the matter. I do appreciate that this is a momentous decision, and whatever we do must be right, because it is a big decision; and depending upon what we do, may hinge a considerable amount of our future prestige. Thank you!

DR. SPARKS: I want to ask a question on Dr. Nafe's remarks, as I understood him, the decision in Ohio to have a stock company. Mr. Stump took part in that discussion. It seems to me that the reason they decided to set up a stock company in Ohio was because of the complications with the law and the Insurance Department. Mr. Stump assured us that we do not have that difficulty here.

DR. NAFE: May I answer that as I understood it? I understood that the reason the Ohio State Society did accept the stock company plan was that they understood that in Michigan there was a tendency on the part of group organizations to get control of the company by voting their mutual stock—the stockholders really become the owners of that company—I mean the policy holders, and if they can give their proxies to some of their leaders, they would get hold of the company. That is the argument I was told by Dr. Young.

MR. STUMP: Referring to the question that was asked by Dr. Sparks concerning an explanation made by Dr. Young, of Ohio, who spoke on the fact that they decided to use a stock company plan instead of the mutual company plan, Dr. Young raised this objection to the mutual company plan:

In the mutual company the policy holders are the ones who control the company, either by their own vote or by proxy. He took the view that the policy holders are in a position where they can control the company, then you might have a situation where you already have large organized groups who could bring themselves together to speak as a unit. But my reply to that, Dr. Sparks, was, as you will recall, that in the State of Indiana we have a law that I don't believe is quite the same as the law in the State of Ohio, and that the distinction between the two statutes rests in this, that in the State of Indiana there can be an indefinite proxy issued by the person who holds the policy. That proxy is not limited to any particular time. The policyholder can give it to be in effect as long as the policy is in effect. Now if the policyholder gives such a proxy to the Board of Directors to act as a proxy committee, then the Board of Directors would continue to vote the proxy unless the policyholder attended the meeting. There was a question as to whether or not he could revoke his proxy. They might select and have a group that would be the dominating group. On the other hand, if you put up the money for a stockholder's plan, you have to put up considerably more than it would require on the estimates that have been given here, and I take the estimates that have been given by Dr. Mitchell. It would require first \$100,000, instead of \$25,000 as a mutual company would require, and the original acquisition costs, so you would have, I believe, at least \$150,000 to be raised. If it were raised and put in a stock company, the members of the medical profession would then have this situation: if the same organized groups determine to control that company, they could either pull out of that company and let it sink, in which event your \$150,000 would be at stake, or if they refused to be enrolled, you, of course, wouldn't have any business upon which to support yourself; that is to say, if those groups of the majority of policyholders vote to act contrary to the interest of the insurance company. Likewise if those same groups attempt to control the mutual plan, they could probably succeed in that. However, they could break the one plan if they had enough of the enrollment that the plan could not operate without these groups.

Now, looking at the mutual plan. Suppose the mutual plan has enough to operate without these organized groups, then you do not have them in control. If the majority of your enrollment does not come from those two large groups, you would still be in control of your own company.

The situation in the State of Indiana is an uncertain one except as we may measure it by the results which have attended the effort of the Hospital Association to organize the Blue Cross plan. They have, up to the present, succeeded in obtaining over \$30,000 in enrollment fees. That does not mean that there are 30,000 people enrolled, but enrollments are coming right on in. They came first from

small groups, but many of those groups were not organized at all. What constitutes a group? With the hospital plan, five or more are necessary to constitute a group. Now what else? Only one thing is absolutely necessary—that is that the group organizing itself appoint one person to collect the group's premiums and turn them in. It is not a matter of individual solicitation. So you might also have a situation where your unorganized groups would be larger than your organized groups. But if that were not true, then you do not gain much in safety by putting up \$150,000 in obligations which could not be repaid except as it would be repaid in dividends. The obligation to repay on the advanced funds, which might be \$50,000, would be shown by certificates of advancement which would be repaid, of course, as to principal and interest out of the earned surplus; and these companies, so far as we have been informed (I don't know as much about them as Dr. Young with regard to the details), have all accumulated an earned surplus, and I think those who invest would be reasonably certain of their money.

(Shall I answer also the question of Dr. Daniels?)

I understand, Dr. Daniels, you want to know what happens about the \$25,000 deposit if the thing does not succeed.

Your \$25,000 that is on deposit with the Department of Insurance is there exactly the same as if you had deposited the \$100,000. It is used then to pay the debts of the corporation upon its liquidation.

DR. DANIELS: That's what I thought.

MR. STUMP: You are entirely correct, and that would be true of either form. And then there isn't any money.

Now there is another thing that I think may interest you. Suppose that you have had profitable experience for a while and have repaid out of your earned surplus the \$25,000 which was advanced as a deposit with the state, and the certificates of advancement which were contributed for overhead, but at present the mutual company would be in debt that amount, then what is to be done? Until you have accumulated a surplus of \$100,000 as required by law in the State of Indiana, you are required to have a contingent provision in the policy. The contingent provision is that the policyholder will pay one additional premium, if necessary, to pay policy claims. If the premium were 95c for a single individual, you would have a 95c liability for a contingent payment. But if you get \$100,000 ahead, constituting earned surplus, that contingent premium would no longer be required to be in the policy.

THE PRESIDENT: Dr. Nafe has asked for just another word.

DR. NAFE: I did want to say that while I have no set ideas personally as to how this should be done, I do know this, that your president appointed the committees, both Study Committee and Reference Committee, without any regard as to how

they stood on this matter. They were picked because they were able leaders in the profession. I feel personally that they have studied it more carefully than I, or any of the rest, and I will say to you that if I had a vote I would probably feel that since they had studied it, both of them extensively and with considerable time given to it, and because I feel that they are able, conscientious and better informed than I, I would probably vote to sustain their report.

DR. SENSENICH: I think I sense some anxiety, and I also felt some anxiety about the state association entering into the insurance field. We are now discussing the matter of lessening the cost of acquisition of this business by having it sold by the Blue Cross. I don't know that the medical profession controls the Blue Cross, and I am wondering whether this mutually-organized mechanism might be organized to represent the medical profession with the public but bring some other insurer into the picture to actually carry the risk; I mean to relieve the Medical Association of the responsibility.

I think concerning the \$25,000 under discussion that in the event the \$25,000 is exhausted your company may pass out of business. Actually what happened in Michigan, when the Insurance Department said they could no longer do any business unless they got secured funds from somebody else, was that the Blue Cross loaned them the money. So it is an insurance proposition set up for the safety of those who buy policies, and I am wondering why we can't clear the one point, that the state medical association could control the company but leave the actual business part of it to some company who was willing to contract, and that that contractor be changed at any time if they were unreasonable in their rates.

MR. STUMP: I don't know of any place that that has been done. I have this impression, however, that there is such a thing, of course, as underwriting in this kind of insurance, that is, one taking the risk for another company. But it seems to me that if the medical profession has a corporation which is of its own making and its own control, then if they re-insure their policies they increase the burden because the next company operates as a re-insurer and the re-insurance premium adds to the cost because that has to be paid from the first company into the second company. The second company which re-insures generally only exists for the purpose of making certain that the claims will be paid. Now the provision that would be in your policies for a contingent liability for an additional month's premium would probably make certain that you would never go completely broke, for this reason: your policies are written for only one month; your people begin to drop out; your liabilities decrease; others come in, and as long as they are coming in and are put on a solid basis, actuarially, you don't have the situation of an insurance company whose obligation might extend over years. Your obligation extends only one month. Then the

company has no liability any more unless further premiums are paid in. For that reason, it seems to me, the re-insurance provision would not be needed, and need not be contemplated, for it would only burden your plan.

DR. SENSENICH: Admitting that there would be some additional burden, I am not speaking of that. I think the only approach is by mutual non-profit. It would seem that that company might be permitted to sublet its insurance if that proved the simpler and possibly the safer way.

MR. STUMP: I think the Insurance Department would not prohibit that sort of thing.

THE PRESIDENT: It's twenty minutes to one and lunch is waiting for us. I would like to entertain a motion to recess until two o'clock.

(Motion carried.)

Afternoon Session—Reconvened at 2:00 P.M.

THE PRESIDENT: It has been suggested at this time that we take a moment to note the death of Miss Dillan, who for many years acted as reporter in this body. Please stand a moment.

(All present stood in tribute to Miss Dillan.)

THE PRESIDENT: We are ready to proceed with the debate.

DR. STOCKING: I thought it might be in order to make a report about the Blue Cross organization for the information of the House, since there have been several questions asked in reference to its activities and to its relationship to the medical profession in this state.

Last spring, early, the committee which had been appointed by the Indiana State Hospital Association to organize a Blue Cross service plan in this state began to function, and the news of this came first, I believe, to the members of two medical specialties who are most vitally interested—the radiologists and pathologists. The state organizations of these two specialties at once met and passed resolutions which were duly sent to the secretaries of the various county societies, recommending that their services not be included in this plan. In other states, when the Blue Cross began to organize, the medical profession did nothing; they waited until the whole thing was cooked and ready to serve and then made a great uproar about how it had been done. We felt that a better method would be to get it in its early organizational phase, to shape the thing closer to our desires. This we did. Members of the two societies were appointed to meet with the committee of the hospital association at their invitation. Dr. Dodds, of Crawfordsville, was appointed by the pathologists, and I was appointed by the radiologists. We met with this committee in their original meeting. Tom Hendricks was there, and other members of the profession had been invited although they did not come. Now I will skip a lot of development here, but after considerable negotiation in which there was a surprising lack of acrimony, and a very cooperative attitude on the part of the hospital members, we agreed to the inclusion of x-ray, laboratory anesthesia, and phys-

ical therapy on the Blue Cross contract with certain provisos. We did this because, in the absence of a medical service plan to go with the Blue Cross, the Blue Cross contract certainly would not have been saleable in competition with existing commercial insurance, industrial insurance, and we felt that the contract offered by the Blue Cross would be superior in that it would offer the low-income group more service for less money. So we allowed this inclusion, as I say, with the following provisos:

First, they had to be labeled in the contract as professional services, not hospital services. If you saw one of the present subscriber's contracts, you would see that the contract says that the service plan will furnish certain hospital services, and in addition they will pay for certain professional services, and these are listed specifically.

The second proviso was that these services had to be paid for on a fee-for-service basis. In other words, the service rendered had to be paid for rather than being included as a part of a per diem rate paid the hospital as an inclusive rate for a number of services. That also is being done.

The third proviso was that if and when the medical service plan was inaugurated or approved or sponsored by the Indiana State Medical Association that these professional services be included—be changed from the hospital policy to the medical policy.

Throughout the state of organization the hospital association asked for advice from the medical profession, and Dr. Dodds and I did our best, and Dr. Combs who has been in on the organizational phase. We also consulted the Executive Committee of our state association. I believe Dr. Sensenich asked what the opportunity for control our medical association has in the Blue Cross. The answer to that is that we have at the present time three members on the Board of Directors of the Indiana Blue Cross, and as soon as we receive names for appointment from the Executive Committee, there will be two more. Dr. Dodds and I, and Dr. Combs, accepted a membership in this because we felt that we could represent our profession better than from the outside. I think we all still feel that it would have been more desirable from the ideological or academic standpoint to have been out, but for practical purposes we felt that the compromise we accepted was the best workable plan.

The present membership of the Board of Directors is:

Mr. Benjamin Blumberg, of Terre Haute, who put up the \$25,000.

Dr. Combs, of Terre Haute.

Sister Mary Reginald, superintendent of the Mt. Mercy Sanitarium at Dyer.

Dr. L. A. Pittenger, president emeritus of Ball State College, Muncie.

Dr. Wemple Dodds, of Crawfordsville.

Dr. B. W. Stocking, of Muncie.

Mr. William P. Flynn, vice-president of the Indiana National Bank.

Miss Helen Teal, of the Indiana State Nurses Association.

Mr. Hugh Landon, of the Fletcher Trust Company.

Mr. Robert Wyatt, of the Indiana State Teachers Association.

Mr. James R. Heyward, vice-president of the Corcoran & Metal Products Corp., of Washington.

Dr. John Benson, superintendent of the Methodist Hospital, Indianapolis.

Mr. Frank Sheffler, superintendent of the Union Hospital, Terre Haute.

Mr. Howard Johnson, superintendent of the Marion General Hospital, Marion.

Mr. Raymond Harp, who represents the AF of L.

Mr. Walter Frisbie, who represents the CIO.

A mutual insurance company was organized under the laws of the State of Indiana with \$25,000 to be deposited. Twenty-five thousand dollars in advance premiums was collected on contracts sold, and the contracts became valid as of November 1. In other words, the outfit is in business. Since I have been active in this thing, I tend to take a bit of proprietary pride in spite of the fact that I went into it to protect the medical profession. At the present time the organization has 3,400 contracts in force, covering 7,500 people, and has approximately 30,000 in the process of enrollment. I think that is about all there is to say about it.

At the present time, five members of the medical profession who are to be suggested by the Indiana State Medical Association, are provided for in the By-Laws for the Board of Directors, and I believe that if industrious, cooperative men are appointed to the Board that the medical profession can retain control of this project.

THE PRESIDENT: In your discussion on the question . . .

DR. CROCKETT: Shall I re-read the motion?

DR. CROCKETT: Your committee recommends and moves that this prepayment plan of health insurance should be sponsored by the State Medical Association and organized and operated by members of this association who have been selected and appointed by the president of this association with advice of the Council.

DR. DANIELS: Mr. Chairman, there is something that I have been studying about, and that is that this is mostly hospital, men that operate the coverage is in that group. I lance a few boils and give a little calomel; I keep as many out of the hospital as I can who don't need to go there, because it costs like the devil, and I can't understand why the people who really need coverage—we are a little afraid to undertake that, that is the general practice man, and I am a general man—just don't understand why Bill Smith would have to go to the hospital before he could be covered. It looks as if the general fellow, unless he is lucky enough to have a better clientele than I have—all my people would have an awful time raising the dough to go to the hospital, and I have treated them now for forty-four years, most of them on the outside,—I just would like

to ask if there are any other general practitioners here. I just wonder if there are any present.

Question.

THE PRESIDENT: Are you ready for the question?

DR. KENNEDY: There has been a good deal of discussion as to the various types of organization. There seems to be no meeting of mind as to the type of organization that would be suitable to the needs that we must attend to under the resolution as proposed by the committee. It is imposed upon them that it shall be an organization not only controlled but financed and operated by the medical association. To that there is very substantial objection by many men. I now propose an amendment which will permit the organizing committee to adopt such plan as may seem most desirable, after full consideration. I propose to amend the committee's resolution by substituting after the words "medical association" the following, "either organized and operated *or directed* by members of this association."

That phrase will give the organizing committee an opportunity either to organize a company by the medical association alone or to sublet it to some regular insurance company if, in their judgment, that seems the better plan to do. It would seem by adoption of this amendment to make possible agreement between all of us and put the final burden upon the organizing committee, who will be in better position to get all the facts assembled and to decide upon that type of organization which will fit the needs of the people and suit most of our men.

THE PRESIDENT: I want Dr. Kennedy to read this original motion and read the words which he desires to substitute in their proper place.

DR. KENNEDY: Your committee recommends and moves that this prepayment plan of health insurance should be sponsored by this State Medical Association and organized and operated by members of this association who have been selected and appointed by the president with the advice of the Council. With the proposed amendment, the recommendation will read:

Your committee recommends and moves that this prepayment plan of health insurance should be sponsored by this State Medical Association, and either organized and operated *or directed* by members of this association who have been selected and appointed by the president with the advice of the Council.

DR. GIORDANO: Dr. Crockett, I have their permission to accept that. I accept that amendment.

DR. CATLETT: It seems to me that this is a place where this organization is either organizing this insurance company or else turning it over to an insurance company, and I would like to make a motion to amend these other motions that we vote first to see whether this association wants to have this insurance carried by an insurance company or by the Indiana State Medical Association.

THE PRESIDENT: The motion is to amend the

amendment by stating—will you state that again Dr. Catlett?

DR. CATLETT: That this society vote as to whether they want an insurance company to carry this risk, or whether the Indiana State Medical Association wants to carry it.

THE PRESIDENT: Do you understand the question? The question is, whether or not we are going to have an insurance company run by this society, or whether we are going to turn this whole matter over to an insurance company to run it. It seems to me that we have come to a crossroad at that point.

Question.

DR. SENSENICH: That is a bit confusing to most of us. Up to this time you have proposed to set up an outside organization to conduct this insurance matter, and then an amendment which makes it optional to the committee as to whether they should operate the insurance company, or whether they, in turn, could interest some private company to carry the risk, or whatever seems best. Now the motion goes beyond that, I mean the last amendment submitted, whether the society wants to run it or let an insurance company run it.

DR. CATLETT: We are either going to have an insurance company to carry this, or we are going to direct some manner or means of doing it. In other words, the men that favor turning this over to some insurance company haven't very much to say about it.

DR. SENSENICH: Then if I understand you correctly, Dr. Kennedy's amendment was to place the option, to place it with the committee, and now you want the House of Delegates to decide.

THE PRESIDENT: Dr. Sensenich, we have not voted. The question that was voted on and approved that you referred to was that your committee recommends and moves that the State Medical Association approve and sponsor a non-profit mutual prepayment type of insurance. Now the question is on the doctor's amendment to the amendment.

DR. SENSENICH: This involves the original motion already voted upon.

THE PRESIDENT: No, it does not conflict with the motion that was passed earlier.

DR. NIE: Mr. President, I think we are now coming to see the light. We are beginning to realize the responsibility of what we are about to take on. This thing of going out and organizing a non-profit, mutual indemnity company is not as simple as it looks, and to go out and hire someone to do it for us, is not easy; if he is a good man, he is already employed; and if he is no good, we don't want him. We can't go out and look in a Sears-Roebuck catalog and hire somebody to run it for us. Good men are working either for themselves or for somebody else. None of us here is smart enough to organize it and run it ourselves. It is a question of whether we want to go in, hands tied, on this vote and operate an indemnity insurance company, or whether we are going to try and get somebody else to run

it for us. Do you think there is any organized insurance indemnity company dumb enough to take the business that we write and pay us a profit? They don't want this stuff that a lot of you folks will write. They will say, "Well, we can't depend on that; we want men that are employed, that are getting a certain wage every week, and where the factory collects the whole premium." You will be getting one man here, one man there, and maybe one fellow working in a grocery store, on a farm, on the highway, but no large group, and you will get smaller groups. Old-line companies get their indemnity stuff from companies that have tens of thousands of people employed. They are all working on the job. They have a doctor that determines their state of health; they are people who don't move around a lot. But the people you will write with this outfit (I will call this an outfit) are the kind that an old-line indemnity insurance company won't take. I am not talking from hearsay. I spent some years in the insurance business. If you have life insurance you should realize that the old-line insurance companies know the expectancy at various ages and can determine death rates accurately, but they know that this kind of insurance, which you are going to start here, is the kind of stuff that fluctuates too much. *You can't get a figure on it, and no good company will buy it from you.* Again I say, stay out of it.

DR. WRIGHT: I think both of these amendments have only served to confuse the motion. I think the vote on the original motion will settle either one of these, and after that is disposed of, then if someone has some further motion, all right; but it seems to me that the original motion, if decided, will carry the intent of the two amendments.

DR. WEINSTEIN: I don't think we can vote today on this last amendment. It is not possible to vote *aye* or *nay* on this last amendment.

DR. CATLETT: I will withdraw my motion and see what happens.

THE PRESIDENT: Does the House give Dr. Catlett consent to withdraw his motion?

(Consent.)

THE PRESIDENT: We are ready to vote on Dr. Kennedy's amendment.

FROM THE FLOOR: Wasn't that accepted by the committee as part of the original motion? Wasn't the motion with the amendment accepted to be voted on?

DR. DANIELS: Am I fogged? Didn't we call the roll down so far, and then we got to talking around with others, and then we went to eat?

THE PRESIDENT: You're fogged up George.

DR. KENNEDY: The statement of the Chair will permit this statement, with which he may not agree.

The vote now is to be taken on the original proposal of the committee, as amended by my motion.

THE PRESIDENT: Dr. Kennedy, I beg your pardon, but that amendment has not been accepted by the House. The only way we have of disposing

of that motion is to either have it withdrawn or voted on.

The purpose of the amendment is to give additional leeway in selecting the method of organization and the type of organization. It has no other purpose. The resolution as proposed by the Committee is: Your committee recommends and moves that this prepayment plan of health insurance should be sponsored by this State Medical Association and organized and operated by members of this association who have been selected and appointed by the president of this association with advice of the Council.

In other words, it provides that the organization of insurance must be run by the association itself. The amendment adds the words "or directed." As that is amended, it will read this way:

Your committee recommends and moves that this prepayment plan of health insurance should be sponsored by this medical association and organized and operated or directed by members of this association who have been selected and appointed by the president of this association with advice of the Council.

It adds the two words "or directed."

DR. SPARKS: I don't believe that this House would want to give that much leeway to a committee. I don't think the committee would want the responsibility. I think that should be decided by the House.

DR. ROMBERGER: I think it is very possible to allow this committee this leeway because nothing this committee does is going to be effective until it is approved by the House of Delegates.

THE PRESIDENT: As many as favor Dr. Kennedy's amendment will stand.

(The vote was counted—47 *yes*)

As many as oppose the amendment will stand.

(The vote was counted—49 *no*)

The amendment is lost by a vote of 47 to 49.

Now then we are voting on the original resolution again. The secretary will call the roll.

The thing that you are voting for now is: Your committee recommends and moves that this prepayment plan of health insurance should be sponsored by the State Medical Association and organized and operated by members of this association who have been selected and appointed by the president of this association with the advice of the Council.

<i>County</i>	<i>Delegate—Response</i>
Allen	Wright—No
	Lohman—I would like to ask for a bit of information. Our delegation has been instructed to vote against any plan whereby the state association would be the insuring agent. Will the state be the insuring agent?

THE PRESIDENT: You will have to answer that yourself, Doctor.

DR. DANIELS: Read it once more, for God's sake.

THE PRESIDENT: Your committee recommends

and moves that this prepayment plan of health insurance should be sponsored by the State Medical Association and organized and operated by members of this association who have been selected and appointed by the president of this association with the advice of the Council.

<i>County</i>	<i>Delegate—Response</i>
	Lohman—No
	Catlett—No
	Dudding—
Bartholomew	Turley—No
Benton	Schaa—No
Boone	Adams—Yes
Carroll	Egan—Yes
Cass	Buckley—No
Clarke	Maurer—Yes
Clay	Beardsley—Yes
Clinton	
Daviess—	
Martin	Fox—Yes
Dearborn—	Fletcher—Mr. President, I would like to ask a question in regard to the directors (committee) that will be appointed by the president. What will be their term of office?
Ohio	

THE PRESIDENT: No information about that—you will have to use your own judgment.

<i>County</i>	<i>Delegate—Response</i>
	Fletcher—No
Ohio	Fessler—Yes
Delaware—	
Blackford	Stocking—Yes
	Ball—Yes
Dubois	Blessinger—No
Elkhart	Yoder—Yes
Fayette—	
Franklin	Glaser—Yes
	Smith—Yes
Floyd	Polhemus—(Left)
Fulton	Stinson—No
Gibson	Clark—No
Grant	Lavengood—No
Hamilton	Donahue—
Hancock	Ferrell—Yes
Harrison	Amy—No
Hendricks	Scamahorn—
Howard	Conley—Yes (by instruction)
Huntington	Nie—No
Jay	Cring—No
Knox	Boyd—Yes
Lake	Verplank—No
	Row—Yes
	Pettibone—
	Jones—Yes
LaPorte	Kelly—Yes
Lawrence	Dollens—No
Madison	Elsten—No
	Jones—No
Marion	Garceau—No
	Moore—No
	Myers—Yes
	Bakemeier—No
	Ochsner—No
	Rupel—No
	Moser—No
	Morton—No
	Ritchey—No
	Manion—No
	Hahn—No
	Gatch—No
	Dalton—No
	Mitchell—Yes
Marshall	Thompson—Yes

<i>County</i>	<i>Delegate—Response</i>
Monroe	Hepner—Yes
Montgomery	Collett—No
Parke-	
Vermillion	Casebeer—No
Porter	Frank—Yes
Posey	Ranes—No
Putnam	Wiseman—No
Randolph	Dininger—No
Ripley	Smith—No
Rush	Atkins—No
St. Joseph	Giordano—Yes
	Balla—Yes
	Carter—Yes
Shelby	Inlow—Yes
Sullivan	Crowder—No
Tippecanoe	Van Reed—Yes
	Thomas—Yes
Vanderburgh	Miller—No
	Welborn—No
	Acre—No
Vigo	Nay—No
	Topping—No
Wabash	Brubaker—No
Wayne-Union	Ross—No
	Thompson—No
Wells	Wybourn—Yes
White	Gable—

Councilors

1st District	Barclay—No
2nd District	Wadsworth—Yes (by instruction)
3rd District	Hauss—Yes
4th District	Elliott—Yes
5th District	Mitchell—No
6th District	Kennedy—Yes
7th District	Portteus—Yes
8th District	Not present
9th District	Romberger—Yes
10th District	Howard—Yes
11th District	Black—No
12th District	Sparks—Yes
13th District	Ellison—Yes

Past Presidents

Davidson—No	Sensenich—Yes
Shanklin—Yes	Van Buskirk—
Combs—No	Ruddell—No
Daniels—No	Mitchell—No
Crockett—Yes	Austin—No
Weinstein—No	McCaskey—Yes
Padgett—(Left)	

56 voting *no*, 42 voting *yes*—I declare the motion lost.

DR. CROCKETT: I move that the president, with the advice and approval of the Council, appoint a committee which is representative of the physicians, both as to geographical distribution and as to kinds of practice, to work out a plan to carry into effect the provisions of the motions already adopted relating to this report.

Motion seconded.

THE PRESIDENT: It is moved and seconded that the president, with the advice and approval of the Council, appoint a committee which is representative of the physicians, both as to geographical distribution and as to kinds of practice, to work out a plan to carry into effect the provisions of the motions already adopted relating to this report.

Those provisions are:

That the State Medical Association approve a prepayment plan of health insurance; and that

The State Medical Association approve and sponsor a non-profit mutual indemnity type of prepayment health insurance. Those are the motions that have been passed, and this motion provides that the president appoint a committee to carry them out.

DR. HAUSS: I would like to offer an amendment to that final motion. I think we have all seen here today that there is quite a diversity of opinion in regard to this report and the question, thus I believe that we should proceed slowly in carrying out the mandates of this House of Delegates, and I believe that this House of Delegates should see the final draft and the final organization of this plan before they approve. I therefore offer as an amendment to the motion, as read, the following,—which plans and provisions shall not be placed in operation until said completed plans and provisions and contracts are submitted to this House of Delegates for final approval or rejection.

DR. ROMBERGER: I wish to second that motion.

THE PRESIDENT: It has been moved and seconded that this amendment be added, and that it will then read like this:

I move that the president, with the advice and approval of the Council, appoint a committee which is representative of the physicians, both as to geographical distribution and as to kinds of practice, to work out a plan to carry into effect the provisions of the motions already adopted, relating to this report, which plans and provisions shall not be placed in operation until said completed plans and provisions and contracts are submitted to this House of Delegates for final approval or rejection.

Do you understand that?

Question.

DR. TOPPING: It seems that this kind of a motion will tie this committee's hands and allow them to consider only one possible plan. The second motion that was passed specified that we were in favor of a mutual non-profit organization. That does not allow the committee that you are going to appoint, if this last motion is carried, to even consider turning this insurance problem over to an old-line insurance company for its administration, or to consider any other type of a plan except a mutual non-profit plan.

DR. HAHN: Mr. President, the air would be cleared if that proposition which was voted upon before lunch were reconsidered. It is far too specific. It prevents the consideration of other plans of action. Unfortunately, I can't move for reconsideration, but it would be proper for someone who voted *yes* to ask for it.

DR. CASEBEER: I voted *yes* for the second amendment, and I would like to have the second amendment reconsidered, and that will clear the air entirely.

THE PRESIDENT: A motion to reconsider is in order if it is proposed by someone who voted for the

motion originally. And this motion to reconsider is also debatable if you want to talk about it.

DR. MILLER: I second that motion to reconsider.

THE PRESIDENT: Then the question before the House is a reconsideration of the second proposition passed this morning.

The motion is to reconsider this motion which was passed this morning, that the State Medical Association approve and sponsor a non-profit mutual indemnity type of prepayment health insurance. As many as are in favor of reconsideration will say *aye* when your name is called. If you oppose, say *no*. The secretary will call the roll.

DR. DANIELS: How does this differ? Now where are we?

THE PRESIDENT: We are voting to reconsider the motion that was passed this morning, which we may do on the same day. It was passed this morning.

<i>County</i>	<i>Delegates—Response</i>
Allen	Wright—Yes Lohman—Yes Catlett—Yes
Bartholomew	Dudding—
Benton	Turley—Yes
Boone	Schaaf—Yes
Carroll	Adams—Yes
Clarke	Buckley—Yes
Cass	Egan—Yes
Clay	Maurer—Yes
Clinton	Beardsley—Yes
Daviess-	
Martin	Fox—No
Dearborn-	
Ohio	Fletcher—Yes Fessler—Yes
Delaware-	
Blackford	Stocking—Yes Ball—Yes
Dubois	Blessinger—Yes
Elkhart	Yoder—No
Fayette-	
Franklin	Glaser—No Smith—No
Floyd	Polhemus—(Left meeting earlier)
Fulton	Stinson—Yes
Gibson	Clark—Yes
Grant	Lavengood—Yes
Hamilton	Donahue—
Hancock	Ferrell—Yes
Harrison	Amy—Yes
Hendricks	Scamahorn—
Howard	Conley—Yes
Huntington	Nie—Yes
Jay	Cring—Yes
Knox	Boyd—No
Lake	Verplank—Yes Row—Yes Pettibone— Jones—Yes
LaPorte	Kelly—Yes
Lawrence	Dollens—No
Madison	Elsten—Yes Jones—Yes
Marion	Garceau—Yes Moore—Yes Myers—Yes Bakemeier—Yes Ochsner—Yes Rupel—Yes Moser—Yes Morton—Yes Ritchey—Yes

<i>County</i>	<i>Delegates—Response</i>
	Manion—Yes Hahn—Yes Gatch—Yes Dalton—Yes Mitchell—No
Marshall	Thompson—No
Monroe	Hepner—Yes
Montgomery	Collett—Yes
Parke-	
Vermillion	Casebeer—Yes
Porter	Frank—Yes
Posey	Ranes—Yes
Putnam	Wiseman—Yes
Randolph	Dininger—Yes
Ripley	Smith—Yes
Rush	Atkins—Yes
St. Joseph	Giordano—

DR. GIORDANO: You have a majority—I move that we go on and not waste time calling names.

<i>County</i>	<i>Delegate—Response</i>
	Giordano—Yes Balla—Yes Carter—Yes
Shelby	Inlow—No
Sullivan	Crowder—Yes
Tippecanoe	Van Reed—Yes Thomas—Yes
Tipton	
Vanderburgh	Miller—Yes Welborn—Yes Acre—Yes
Vigo	Nay—Yes Topping—Yes
Wabash	Brubaker—Yes
Wayne-Union	Thompson—Yes Ross—Yes
Wells	Wybourn—No

Councilors

Barclay—Yes	Clauser—
Wadsworth—No	Romberger—Yes
Hauss—Yes	Howard—No
Elliott—Yes	Black—Yes
Mitchell—Yes	Sparks—No
Kennedy—No	Ellison—Yes
Portteus—Yes	

Past Presidents

Davidson—Yes	Padgett—
Shanklin—No	Sensenich—Yes
Combs—Yes	Ruddell—Yes
Daniels—Yes	Austin—No
Crockett—No	McCaskey—Yes
Weinstein—Yes	

THE PRESIDENT: The House having voted 80 to 17 to reconsider the second motion that was passed this morning, I declare that motion open for reconsideration.

DR. TOPPING: Mr. President, in reconsideration of that motion, I would like to offer an amendment to that motion, as follows: That the words "mutual non-profit" to be deleted from the motion. That leaves the motion that we are in favor of an indemnity plan of prepaid insurance for the State of Indiana.

THE PRESIDENT: Is there a second to Dr. Topping's motion?

DR. SPARKS: It is out of order.

THE PRESIDENT: We are now at the point where

we are considering this second proposition, an amendment. State your point of order, doctor.

DR. HAHN: My point of order is this: If my memory is correct, *Robert's Rules of Order* provide that an affirmative vote to reconsider defeats the previous passage of a motion.

THE PRESIDENT: Mr. Stump, will you help the Chair on this?

MR. STUMP: Under *Robert's Rules of Order*, if you will permit me to read it, the effect of the adoption of this motion is to place before the assembly the original question in the exact form it occupied before it was voted upon.

THE PRESIDENT: So we are right back exactly on the question that was passed this morning, and that may be amended. Therefore Dr. Topping's motion to amend is in order.

DR. WEINSTEIN: Mr. President, May I simply ask, as a matter of information—that amendment, as I understand it, the motion as amended, simply means that we are going to vote on the indemnity plan and nothing else?

THE PRESIDENT: If you will give me a moment, I will read the first motion that was reconsidered. It was that the State Medical Association approve and sponsor a non-profit mutual indemnity type of prepayment health insurance, and the amendment to that motion is:

Your Committee recommends and moves that the State Medical Association approve and sponsor an indemnity type of prepayment health insurance.

The words that were left out there are, "non-profit" and "mutual."

DR. CATLETT: May I interrogate Dr. Crockett? In the report of your committee, as reported October 5, the words "mutual" and "non-profit" did not occur in that part of your resolution.

DR. CROCKETT: That is correct.

DR. CATLETT: May I ask the reason for changing that?

DR. CROCKETT: In presenting the motions today, I said there had been some elaboration, so that this became the fourth resolution instead of the second. It did not change the meaning.

FROM THE FLOOR: Will someone explain what the controversy is over the words "mutual" and "non-profit"?

THE PRESIDENT: I will have to ask you to re-state your question.

FROM THE FLOOR: The question is, what the words "mutual" and "non-profit" mean that you desire them deleted?

DR. TOPPING: A mutual, non-profit organization furnishes a certain specific type of insurance coverage, and I do not think this committee, which it is contemplated appointing, should be tied down to that one type. I think that they should be free to consider any type of insurance coverage, and as long as it is an indemnifying type of contract it won't prohibit them from considering a mutual, non-profit type, but it will allow them to consider other types, too. I don't think this committee should

be limited to a consideration of one type of insurance.

Does that answer your question?

Yes, doctor.

DR. HOWARD: I think that as we consider this, we should give it a great deal of thought. This committee went over this with Mr. Stump, our attorney. It is obvious that ninety-two men will have ninety different opinions, and I think we should take Mr. Stump's analysis as to the pitfalls we will get into and weigh them against the advantages of other types of insurance, and I think in voting on this we should give a great deal of thought to Mr. Stump's opinion.

DR. SPARKS: The Permanent Study Committee has been a whole year studying this. Yes, and we think they did a great job. Our reference committee spent much time on hearings, and I was there a good part of it as an interested member of the association, not as a member of the committee, and we think they did a good job. Their recommendations were brought before the House and turned down. We are going to appoint another committee to do the same thing. I don't see that we are going to get anywhere if we repeat the performance. We will be just exactly where we are now. If we believe our committee did a good job, we should support them. If not, drop the whole thing.

DR. HAHN: Is it in order to offer a second amendment to this motion?

THE PRESIDENT: Yes.

DR. HAHN: I move that the motion be amended by deleting the word "sponsor," and substituting the word "approve"; the word "sponsor" is indefinite. If you substitute the word "approve," it does not grant any authority for taking any definite action.

DR. TOPPING: I will accept that as amended. The second I will accept also.

THE PRESIDENT: Does the House give its consent to the acceptance of that amendment?

Yes.

THE PRESIDENT: Then the motion that is now before the House is, that the words "non-profit" and "mutual" be deleted, and in place of the word "sponsor" the word "approve" be used. As many as favor that motion, stand up.

Those who disapprove, stand up.

The amendment is carried.

THE PRESIDENT: Now then the question open is: Your Committee recommends and moves that the State Medical Association approve an indemnity type of prepayment health insurance.

Are you ready for that question?

Question:

As many as favor that, stand up.

The motion is carried.

THE PRESIDENT: I think we are ready to go on with that second revised motion, and we are ready to discuss the question that it has been moved that the president, with the advice and approval of the Council, appoint a committee which is representative of the physicians, both as to geographical dis-

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THE JOURNAL
OF THE
Indiana State Medical Association

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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Office of Publication: 1017 Hume Mansur Building, Indianapolis 4, Indiana

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BOOKS

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AUTHORS

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Allen, Paul W. (Microbes Which Help or Destroy Us)Apr. xxv
Amberson, J. Burns; Dick, George F.; Minor, George R.; Castle, William B.; Stroud, William D., and Eusterman, George B. (The 1943 Year Book of General Medicine)Feb. xxv
American Medical Association (A.M.A. Council on Pharmacy and Chemistry Reports for 1943).....Aug. xxv
American Medical Association (Handbook of Nutrition)Mar. xxv and July xxvi
American Medical Association (New and Nonofficial Remedies, 1944)Aug. xxv
- Bates, William, and Judovich, Benard (Segmental Neuralgia in Painful Syndromes).....Oct. xxvi
Burlingham, Dorothy, and Freud, Anna (Infants Without Families)Aug. xxv
- Carrington, William J. (Safe Convoy—The Expectant Mother's Handbook).....Mar. xxv
Castallo, Mario A., and Taber, Clarence Wilbur (Taber's Dictionary of Gynecology and Obstetrics)Nov. xxviii
Castle, William B.; Stroud, William D.; Eusterman, George B.; Dick, George F.; Amberson, J. Burns, and Minor, George R. (The 1943 Year Book of General Medicine)Feb. xxv
Christian, Henry A. (The Principles and Practice of Medicine)Aug. xxv
Cole, Warren H., and Elman, Robert (Textbook of General Surgery)May 278
Colwell Publishing Co. (The 1945 Daily Log for Physicians)Dec. xxvi
Corry, Sarah (Notes on Nursing by a Nurse).....Aug. xxiv
de Lorimier, Alfred A. (The Arthropathies, A Handbook of Roentgen Diagnosis).....Feb. xxv
- Dick, George F.; Amberson, J. Burns; Minor, George R.; Castle, William B.; Stroud, William D., and Eusterman, George B. (The 1943 Year Book of General Medicine)Feb. xxv
- Ebert, Elizabeth, and Simmons, Katherine (The Brush Foundation Study of Child Growth and Development, I. Psychometric Tests).....May xxiii
Elman, Robert, and Cole, Warren H. (Textbook of General Surgery)May 278
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Eusterman, George B.; Dick, George F.; Amberson, J. Burns; Minor, George R.; Castle, William B., and Stroud, William D. (The 1943 Year Book of General Medicine)Feb. xxv
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- Gillies, Carl L., and Kerr, H. Dabney (The Urinary Tract)Oct. xxvi
Gunter, Carl E. M. (Practical Malaria Control)July xxvi
- Herrmann, George R. (Synopsis of Diseases of the Heart and Arteries).....May xxiii
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- Lorand, Sandor (Psychoanalysis Today).....Aug. xxiv
- MacBryde, Cyril M. (The Analysis and Interpretation of Symptoms).....Aug. xxv
Minor, George R.; Castle, William B.; Stroud, William D.; Eusterman, George B.; Dick, George F., and Amberson, J. Burns (The 1943 Year Book of General Medicine)Feb. xxv
Moncrieff, Alan, and Rolleston, Humphry (Minor Surgery)Aug. xxiv
Morrison, A. Cressy (Man Does Not Stand Alone)Aug. xxiv
Murphy, Francis D. (The Diagnosis and Treatment of Acute Medical Disorders).....Nov. xxviii
- Painter, Charles F. (The 1943 Year Book of Industrial and Orthopedic Surgery).....Feb. xxv

- Rehberger, George E. (Lippincott's Quick Reference Book for Medicine and Surgery)-----Aug. xxiv
- Ritter, Joseph Franklin (Nascent Endocrine Therapy)-----Feb. xxv
- Roberts, Katherine Elliott, and Fleming, Virginia Van Dyne (Persistence and Change in Personality Patterns)-----May xxiii
- Rolleston, Humphry, and Monerleff, Alan (Minor Surgery)-----Aug. xxiv
- Rosenow, Edward C. (The International Bulletin—Rosenow Poliomyelitis—Vol. A44)-----Aug. xxv
- Seiffert, Gustav (Virus Diseases in Man, Animal, and Plant)-----July xxvi
- Selling, Lowell S. (Synopsis of Neuropsychiatry)-----May xxiii
- Simmons, Katherine, and Ebert, Elizabeth (The Brush Foundation Study of Child Growth and Development, I. Psychometric Tests)-----May xxiii
- Smith, Frederick C. (Sulfonamide Therapy in Medical Practice)-----Apr. xxv
- Stroud, William D.; Dick, George F.; Amberson, J. Burns; Minor, George R.; Castle, William B., and Eusterman, George B. (The 1943 Year Book of General Medicine)-----Feb. xxv
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- Thewlis, Maiford W. (Metastases, Medical and Surgical)-----Aug. xxiv
- Tobias, Norman (Essentials of Dermatology)-----Mar. xxv
- Weiss, Samuel (Clinical Lectures on the Gallbladder and Bile Ducts)-----Apr. xxv
- Weiss, Edward, and English, O. Spurgeon (Psychosomatic Medicine)-----Apr. xxv and Dec. xxvi
- Yater, Wallace Mason (Fundamentals of Internal Medicine)-----Oct. xxvi
- Industrial Ophthalmology (Kuhn), The C. V. Mosby Co.-----May xxiii
- Industrial and Orthopedic Surgery, The 1943 Year Book of (Painter), The Year Book Publishers, Inc.-----Feb. xxv
- Infants Without Families (Freud-Burlingham), International University Press-----Aug. xxv
- Internal Medicine, Fundamentals of (Second Edition) (Yater), D. Appleton-Century Co.-----Oct. xxvi
- International Bulletin, The—Rosenow Poliomyelitis—Vol. A44 (Rosenow), The International Bulletin-----Aug. xxv
- Lippincott's Quick Reference Book for Medicine and Surgery (Twelfth Edition) (Rehberger), J. B. Lippincott Co.-----Aug. xxiv
- Log for Physicians, The 1945 Daily (Colwell Publishing Co., Champaign, Illinois.) (r.)-----Dec. xxvi
- Malaria Control, Practical (A Handbook for Field Workers) (Gunther), The Philosophical Library-----July xxvi
- Man Does Not Stand Alone (Morrison), Fleming H. Revell Co.-----Aug. xxiv
- Metastases, Medical and Surgical (Thewlis), Charlotte Medical Press, Charlotte, N. C.-----Aug. xxiv
- Medical Disorders, The Diagnosis and Treatment of Acute (Murphy), F. A. Davis Co.-----Nov. xxviii
- Medical Practice, Specialties in (Allen), Thomas Nelson and Sons-----Feb. xxv
- Medicine, The Principles and Practice of (Fifteenth Edition) (Christian), D. Appleton-Century Co., Inc.-----Aug. xxv
- Medicine, The 1943 Year Book of General (Dick-Amberson-Minor-Castle-Stroud-Eusterman), The Year Book Publishers, Inc.-----Feb. xxv
- Microbes Which Help or Destroy Us (Allen), The C. V. Mosby Co. (r.)-----Apr. xxv
- Neuralgia in Painful Syndromes, Segmental (Judo-vich-Bates), F. A. Davis Co.-----Oct. xxvi
- Neuropsychiatry, Synopsis of (Selling), The C. V. Mosby Co.-----May xxiii
- New and Nonofficial Remedies, 1944 (American Medical Association) (r.)-----Aug. xxv
- Nose, Throat, and Ear, Office Treatment of the (Hollender), The Year Book Publishers, Inc.-----Feb. xxv
- Nursing by a Nurse, Notes on (Corry), D. Appleton Century Co., Inc.-----Aug. xxiv
- Nutrition, Handbook of (American Medical Association) (r.)-----Mar. xxv, July xxvi
- Obstetrical Urology, Gynecological and (Everett), The Williams and Wilkins Co.-----Nov. xxviii
- Office Treatment of the Nose, Throat, and Ear (Hollender), The Year Book Publishers, Inc.-----Feb. xxv
- Ophthalmology, Industrial (Kuhn), The C. V. Mosby Co.-----May xxiii
- Orthopedic Surgery, The 1943 Year Book of Industrial and (Painter), The Year Book Publishers, Inc.-----Feb. xxv
- Peptic Ulcer, The Treatment of (Heuer), J. B. Lippincott Co.-----Aug. xxiv
- Personality Patterns, Persistence and Change in (Roberts-Fleming), Society for Research in Child Development, National Research Council, Washington, D. C.-----May xxiii
- Pharmacopoeia of the United States of America, The First Bound Supplement to the (Twelfth Revision), Mack Printing Co.-----July xxvi
- Poliomyelitis, Rosenow—The International Bulletin—Vol. A44 (Rosenow), The International Bulletin-----Aug. xxv
- Principles and Practice of Medicine, The (Fifteenth Edition) (Christian), D. Appleton-Century Co., Inc.-----Aug. xxv
- Psychoanalysis Today (Lorand), International University Press-----Aug. xxiv

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- Allergy in Practice (Feinberg), The Year Book Publishers, Inc.-----May 278
- A.M.A. Council on Pharmacy and Chemistry Reports for 1943 (American Medical Association) (r.)-----Aug. xxv
- Arteries, Synopsis of Diseases of the Heart and (Third Edition) (Herrmann), The C. V. Mosby Co.-----May xxiii
- Arthropathies, A Handbook of Roentgen Diagnosis, The (de Lorimier), The Year Book Publishers, Inc.-----Feb. xxv
- Brush Foundation Study of Child Growth and Development, I. Psychometric Tests (Ebert-Simmons) Society for Research in Child Development, National Research Council, Washington, D.C.-----May xxiii
- Clinical Diagnosis by Laboratory Examination (First Edition, Revised) (Kolmer), D. Appleton Century Co., Inc.-----Aug. xxiv
- Clinical Lectures on the Gallbladder and Bile Ducts (Weiss), The Year Book Publishers, Inc.-----Apr. xxv
- Endocrine Therapy, Nascent (Ritter), The Caxton Printers, Ltd.-----Feb. xxv
- Essentials of Dermatology (Second Edition) (Tobias)-----Mar. xxv
- Gynecological and Obstetrical Urology (Everett), The Williams and Wilkins Co.-----Nov. xxviii
- Health Service, A National (By the Ministry of Health, Department of Health for Scotland), The Macmillan Co.-----July xxvi
- Heart and Arteries, Synopsis of Diseases of the (Third Edition) (Herrmann), The C. V. Mosby Co.-----May xxiii

Psychosomatic Medicine (Weiss-English), W. B. Saunders Co. (r.)	Apr. xxv and Dec. xxvi
Safe Convoy—The Expectant Mother's Handbook (Carrington), J. B. Lippincott Co.	Mar. xxv
Segmental Neuralgia in Painful Syndromes (Judovich-Bates), F. A. Davis Co.	Oct. xxvi
Sulfonamide Therapy in Medical Practice (Smith), F. A. Davis Co.	Apr. xxv
Surgery, Minor (Rolleston-Moncrieff), Philosophical Library	Aug. xxiv
Symptoms, The Analysis and Interpretation of (MacBryde), J. B. Lippincott Co.	Aug. xxv
Synopsis of Diseases of the Heart and Arteries (Third Edition) (Herrmann), The C. V. Mosby Co.	May xxiii
Taber's Dictionary of Gynecology and Obstetrics (Taber-Castallo), F. A. Davis Co.	Nov. xxviii
Textbook of General Surgery (Fourth Edition) (Cole-Elman), D. Appleton-Century Co., Inc.	May 278
Urinary Tract, The (Kerr-Gillies), The Year Book Publishers, Inc.	Oct. xxvi
Urology, Gynecological and Obstetrical (Everett), The Williams and Wilkins Co.	Nov. xxviii
Virus Diseases in Man, Animal and Plant (Seiffert), Philosophical Library	July xxvi
Year Book of General Medicine, The 1943 (Dick-Ambersen-Minor-Castle-Stroud-Eusterman), The Year Book Publishers, Inc.	Feb. xxv

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tribution and as to kinds of practice, to work out a plan to carry into effect the provisions of the motions already adopted, relating to this report.

As many as favor this motion, stand up.

As many as are opposed will stand up.

The motion is carried.

Which plans and provisions shall not be placed in operation until said completed plans and provisions and contracts are submitted to this House of Delegates for final approval or rejection.

As many as are opposed will stand up.

That amendment is carried.

Now then, to make it entirely legal, we will again vote on the motion as amended.

As many as are in favor of the motion, say *aye*.

As many as are opposed . . .

The ayes have it.

DR. CROCKETT: I move the adoption of the report as amended as a whole.

Dr. Thomas seconded the motion.

THE PRESIDENT: A motion as to the resolutions, as approved and amended, be adopted. As many as are in favor of the adoption of the whole program, say *aye*—contrary, *no*.

The motion is carried.

THE PRESIDENT: Now then, there is a question as to when these plans and contracts, et cetera, shall be reported to the House of Delegates. Has anybody got any suggestions regarding that?

DR. CROCKETT: I move that you call a special meeting of the House of Delegates to consider the problem when it is ready for presentation by this committee.

DR. DANIELS: You might say whoever is president.

THE PRESIDENT: Well, it is understood.

You make that motion read that the president of the society shall call a special session of the House of Delegates to consider the plans of the Committee here contemplated, when and if such plans are prepared and ready.

DR. A. T. JONES: I would like to know how much time that will involve.

THE PRESIDENT: Well, the committee will first have to be appointed, and the plans will have to be worked out, and it will be a considerable time before any special session is called again.

As many as favor this, say *aye*, contrary, *no*.

The ayes have it.

DR. A. M. MITCHELL: You will have to get the consent of this body to have the special meeting.

THE PRESIDENT: All right, as many of you as favor a special call of the House of Delegates to consider plans of such committee as will be appointed, please stand.

(Motion carried.)

Any other business for this committee?

Nothing further.

Motion to adjourn is in order.

Meeting adjourned at 3:15 P.M., November 12, 1944.

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

October 2, 1944.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; F. T. Romberger, M.D.; E. M. Shanklin, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; F. S. Crockett, M.D., and T. A. Hendricks, executive secretary.

Statements of receipts and expenditures for September for the association committees and THE JOURNAL were approved.

Membership Report

Number of members October 2, 1944.....	3,345*
Number of members October 2, 1943.....	3,243
Gain over last year.....	102

* Includes 936 in military service and 126 honorary members.

Treasurer's Office

Upon the motion of Dr. Forster, seconded by Dr. McCaskey, the Executive Committee approved the action whereby the recommendation that a special war assessment of \$5 per member for 1945 is to be made to the Council.

1944 Annual Session

Commercial Exhibit:

(a) Sixty-two spaces sold to 59 exhibitors.

(b) Upon the motion of Dr. McCaskey, seconded by Dr. Romberger, the request of the Holland-Rantos Company to show birth control films in the commercial exhibit was rejected.

Planned Parenthood Exhibit. The committee approved an exhibit by the Planned Parenthood Association of Indiana, but did not approve the showing of films, as the Planned Parenthood group had an exhibit at the American Medical Association meeting but so far as could be determined no films were shown.

The request of the British Information Services to show a film on "Rehabilitation" was rejected due to the fact that no arrangements had been made for the showing of films at the state meeting.

Stout Field Inspection Trip. Seventy-seven reservations have been made for Stout Field Inspection trip, at 1:45, Thursday, October 5. Members of the House of Delegates and officers of the state association are invited to take this trip.

Legislative, Legal and Social Security Matters

National

Analysis of Wagner-Murray-Dingell Bill, by Earl E. Muntz, of New York University, to be turned over to Albert Stump.

Local

Bill to amend the present State Board of Medical Registration and Examination law brought to the attention of the committee. This proposed bill was explained to the committee by Albert Stump.

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Prepayment Medical Plans

The committee is to discuss at its next meeting the subject of reimbursing Jay Ketchum for the service he has rendered in Indiana.

Dr. Oliphant named the following Special Reference Committee on Health Insurance: F. S. Crockett, chairman; C. B. Paynter, J. H. Weinstein, T. Z. Ball, and W. L. Portteus.

Organization Matters

Letters in regard to OPA rationing read to the committee and referred to Dr. C. L. Rudesill, chairman of the OPA Medical Advisory Committee.

Upon the motion of Dr. Oliphant, seconded by Dr. Forster, the Executive Committee expressed no objection to the "Doctor Goodhealth" radio program being commercially sponsored, and suggested that this be a matter for discussion by the Council at its meeting on October 3.

War and Postwar Medicine

Letter on "keeping men in service after peace" referred to War Participation Committee.

Letter from a medical officer concerning increase in rank brought to the attention of the Committee. Copies of this letter had been forwarded to Procurement and Assignment Service, to Dr. Olin West, and to General Fred Rankin.

Socialized Medicine

Attention of the committee was called to LaGuardia's New York Plan, to Harry Hopkins' article in *The American Magazine*, and to the statement by Arthur J. Altmeyer, chairman of the Social Security Board, in regard to the hospital becoming "the center of coordinated services for the well and for the sick, a community center for prevention as well as for diagnosis and cure."

The Journal

The Cooperative Advertising Bureau has sent out a questionnaire for a company concerning prescription chemicals, asking "If the doctors in Indiana could be shown in advertising why a certain brand of U.S.P. chemical would make a better suspension, would they specify that make of chemical by name in their prescriptions?" The members of the Executive Committee felt that they could give no guarantee that the doctors could do that.

Paper Situation. Report made to the committee that by careful planning and by holding reprints to a minimum, it seems that despite the large convention issue of THE JOURNAL the paper allowance will not be exceeded.

Excerpts from letters expressing appreciation in regard to the September JOURNAL brought to the attention of the committee. These have come from physicians both in and out of service all over the country.

Medical Defense

Typical letters in regard to the St. Paul Mercury Indemnity plan were discussed by the committee.

PROFESSIONAL PROTECTION**DOCTORS DISCHARGED**

from Military Service should
notify Company immediately.

MILITARY POLICY

does not cover Civilian Practice.

**THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA**

**COOK COUNTY
GRADUATE SCHOOL OF MEDICINE**

(In affiliation with COOK COUNTY HOSPITAL)
Incorporated not for profit

ANNOUNCES CONTINUOUS COURSES

SURGERY—Two Weeks Intensive Course in Surgical Technique starting January 15, 1945, and every two weeks during the year.

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The general reaction to the plan has been good, although there is some misunderstanding in regard to it.

There being no further business, the meeting was adjourned.

LOCAL SOCIETY REPORTS

100% IN PAYMENT OF 1945 DUES

CARROLL COUNTY CLAY COUNTY

Clay County Medical Society members met on October thirty-first at the home of Dr. F. C. Dilley, of Brazil, for a business meeting. The nine members present discussed proposed hospital and medical care plans.

* * *

Dearborn-Ohio County Medical Society members held a meeting October twelfth at the office of Dr. E. R. Wallace, of Aurora. The speaker for this meeting was Mrs. Rose Smith, Dearborn County welfare director. Mrs. Smith discussed the new welfare setup. The delegates also gave a report on the recent state convention. Seven members were present.

On October twenty-sixth the members met at the home of Captain James M. Pfeifer, M.C., of Lawrenceburg, who related some of his experiences while in the Pacific area. Six members attended the meeting.

* * *

Elkhart County Medical Society members met at Hotel Elkhart, in Elkhart, on November tenth, for a dinner meeting. They had as their guests the Northern Indiana Industrial Nurses Association and the St. Joseph County Medical Society. The guest speaker was Dr. Howard W. Haggard, Professor of Physiology at Yale University. Doctor Haggard discussed "Trends in Medical Research." This was followed by a discussion of the proposed pre-payment health insurance program, with instructions to the delegates. The meeting was attended by one hundred members and guests.

* * *

Hancock County Medical Society members honored Dr. Jesse E. Ferrell, of Fortville, president-elect of the Indiana State Medical Association, with an informal reception and dinner at the Cozy Hotel, near Greenfield, on October eighteenth. The wives of the members were guests as well as Thomas A. Hendricks, of Indianapolis, and Dr. W. U. Kennedy, Sixth District councilor, who spoke on the experiences of Henry County in building a county hospital.

* * *

Hendricks County Medical Society members met at Crawley's Hall, at Danville, on November third for a discussion of questions of importance to the society. Eight members were present.

Howard County Medical Society members held a meeting at the St. Joseph Memorial Hospital, in Kokomo, on November third. A symposium of case reports on the use of penicillin was followed by a discussion of the pre-payment plan of health insurance and the annual election of officers.

* * *

Indianapolis (Marion County) Medical Society members met on November seventh at the Indianapolis Athletic Club. After a business meeting, at which the proposed plan for health insurance was discussed, Drs. H. G. Hamer, J. O. Ritchey, and L. D. Carter, all of Indianapolis, presented case reports.

At a joint wartime graduate medical meeting on November fifteenth, the Indianapolis Medical Society met with the staff at Billings General Hospital.

Major I. Arthur Mirsky, M.C., Army Air Force, was the guest speaker at a third meeting held November twenty-first at the Indianapolis Athletic Club. Major Mirsky's topic was "Diabetes Mellitus."

* * *

Lake County Medical Society members held a meeting at the Parramore Hospital, at Crown Point, on November ninth. Dr. Russell Hollingsworth, of the Department of Thoracic Surgery, University Hospital, University of Michigan Medical School, presented "Developments in the Surgical Management of Thoracic Diseases," illustrated by lantern slides. Dr. Lawrence W. Nehil, of Indianapolis, discussed the paper. Fifty members attended the meeting.

* * *

Montgomery County Medical Society members held a meeting at the Culver Hospital, in Crawfordsville, on October nineteenth. A paper on "Modern Treatment of Syphilis in General Practice," was presented by Dr. Norman M. Beatty, of Indianapolis. Twelve members attended the meeting.

* * *

Porter County Medical Society members met at Valparaiso on October thirty-first. The speaker for this meeting was Dr. William H. Howard, of Hammond, who discussed the Indiana plan of medical insurance. Twelve members were present at the meeting.

* * *

Posey County Medical Society members met October twenty-fourth for a resumé of the report of the House of Delegates, and a discussion of the Indiana health insurance pre-payment plan. Six members attended the meeting.

* * *

Vanderburgh County Medical Society members met at the Vedome Hotel on October tenth. The speakers for this meeting were Dr. Mell B. Welborn and Dr. Keith Meyer, both of Evansville, who discussed x-ray studies, and Mr. Earl J. Smith, a representative of the Chamber of Commerce, who urged increased membership and support to meet expanding postwar community needs.

COUNCILOR DISTRICT MEETING**THE SEVENTH COUNCILOR DISTRICT**

The Seventh District Medical Society members held a meeting on November first at the American Legion Home in Franklin. The Indiana Trudeau Society, which is campaigning against tuberculosis, was in charge of the program. The speakers were: Dr. Amos C. Michael, Indiana University School of Medicine, and Dr. Edward W. Custer, Healthwin Hospital, South Bend. Following a dinner, Major Augustus McCravey, chief of the Section on Neurosurgery at the Wakeman General Hospital, at Camp Atterbury, addressed the society on the problems in reconstruction surgery. The paper was discussed by Major Truman Blocker, chief of the Section on Plastic Surgery, at Wakeman General Hospital.

WOMAN'S AUXILIARY*to the**Indiana State Medical Association*

President—Mrs. F. M. Gastineau, Indianapolis
President-elect—Mrs. S. J. Petronella, East Chicago
Corresponding Secretary—Mrs. C. L. Bock, Indianapolis
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis

ALLEN COUNTY

The Allen County Medical Auxiliary met recently at the home of Mrs. J. Cowan. A film, "Psychiatry in Action," was shown by Sheriff Walter Adams and Glenn Speelman. Reports on the state convention were given by delegates who attended. Mrs. Harry Garton reported on her work with the Red Cross Blood Bank. Following the business meeting, tea was served.

CLARK COUNTY

A card party was held at the home of Mrs. C. F. C. Hancock on the evening of October sixth for the medical auxiliary.

DELAWARE-BLACKFORD

Mrs. O. W. Owens was elected president of the Delaware-Blackford Auxiliary, at a meeting held September nineteenth at the home of Mrs. F. E. Dunn. Mrs. Fred Wishard, of Pendleton, legislative chairman of the state organization, was the guest speaker.

LAKE COUNTY

Mrs. J. W. Mather, East Gary, presided at the meeting of the Lake County Auxiliary, held September twentieth at the Woodmar Country Club. Luncheon was served. Lieutenant Commander J. F. Wanless spoke on "Care of the Wounded and Sick in Wartime."

MADISON COUNTY

The opening dinner meeting of the Madison County Auxiliary was held September eighteenth at the Model Inn, with Mrs. Robert Armington and Mrs. Horace James in charge of arrangements. Miss Evelyn McGuinness, who is a member of the staff of the St. John's Hospital, spoke of the work of the hospital.

*(Continued on page xxvi)***3****intensive Post-Graduate Days****days of half-hour lectures****days to hear new ideas****days to renew acquaintances****days to relax away from your own office**

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TIPPECANOE COUNTY

Mrs. F. L. Pyke spoke on "The Advantages of Hospital Insurance" at a dinner meeting held at the Lafayette Country Club on October tenth. Medical news was given, also a report of the state meeting of the auxiliary.

VANDERBURGH COUNTY

October seventeenth the members of the Vanderburgh County Auxiliary met at the Hotel McCurdy, in Evansville, for a luncheon meeting.

The Medical Mrs. Club was entertained at a card party at the Hotel McCurdy on October eleventh. Mrs. Dallas Fickas, Mrs. William Healy and Mrs. P. J. V. Corcoran were hostesses.

IN MEMORIAM

1943-1944

(Womans Auxiliary)

Mrs. Perry C. Prayer—South Bend

Mrs. A. W. Rhind—Hammond

Mrs. F. V. Iddings—Crown Point

Mrs. R. M. Hedrick—Gary

Mrs. Elizabeth Miley—Anderson

Mrs. George Dillinger, Sr.—French Lick

Mrs. Sam Hervey—Fortville

Books

BOOKS REVIEWED

THE 1945 DAILY LOG FOR PHYSICIANS. Colwell Publishing Company, Champaign, Illinois. Price \$6.00, postpaid.

The 1945 *DAILY LOG* is a boon in helping you figure the Pay-as-You-Go Tax. Poor records cost time and money; the LOG is a simple solution to this problem, for you can record charges, receipts and expenses as they come along. Also net profit for the month, for the year, income tax essentials otherwise so laboriously figured, collection losses—these and other items are thus easily located and held for future reference. We recommend that you investigate the 1945 *DAILY LOG*.

PSYCHOSOMATIC MEDICINE. The Clinical Application of Psychopathology to General Medical Problems. By Edward Weiss, M.D., professor of Clinical Medicine, Temple University Medical School, Philadelphia; and O. Spurgeon English, M.D., professor of Psychiatry, Temple University Medical School, Philadelphia. 687 pages. Cloth. Price: \$8.00. W. B. Saunders Company, Philadelphia, 1943.

Psychosomatic Medicine is written for the General Practitioner, in terms that he can readily understand. It deals boldly with the outmoded conception that illness is either functional or organic, and instead emphasizes how much is functional and how much is organic.

The make-up of this volume is one that makes for easy reference. One may read six chapters for a basic understanding of the psychic approach, and then turn to the various specialties for the particular section in which he may be interested. This obviates the necessity of wading through material unrelated to the subject.

It is a work which, while in no sense intended to make skilled psychiatrists of the average practitioner of medicine, will give him the necessary outlook to cope with the minor psychic disorders and enable him to do better work.

M.M.

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